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ABSTRACT

This conference report of the National Society of Allied Health focusses on the theme of health promotion for black Americans, with emphasis on creating cooperative partnerships to address the various social and environmental conditions adversely affecting minority group health status. The keynote speaker provided an historical perspective on health care status of Black and other minorities in America. He pointed out that while health status has improved over the past 85 years for Americans in general, Blacks and other minorities remain far behind on a number of key health status indicators. The report was divided into three sections: 1) health promotion from the community, consumer and religious perspective (This section provided insights and models for improving health status through measures such as holistic insight, education, personal awareness, and the historical need for Blacks to pull together.); 2) health promotion from the business, education and the professional perspectives (It was suggested that the business community best understands the benefits of establishing partnerships to promote health care and that it is tied to economic self-interest for both the business community and the minority health consumer.); 3) research and political perspectives (This section included information on the impact of professional regulation on minority employment in allied health and on Hill-Burton obligations to assure adequate care to poor and rural persons.) The recommendations from the speakers on these topics were that minorities should be more actively involved in health research and that the causes of high infant mortality among Blacks should not be further researched but rather dealt with by action programs designed to close the health status gap. The report closes with listings of the participants, including short descriptions of their professional affiliations. (CG)

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NATIONAL SOCIETY OF ALLIED HEALTH

CONFERENCE REPORT

ANNUAL MEETING

March 29-30, 1985

THE HOLIDAY INN EXECUTIVE CENTER

VIRGINIA BEACH, VIRGINIA

"PARTNERSHIPS IN HEALTH PROMOTION FOR BLACK AMERICANS"

Prepared by:
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Pursuant to:

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NATIONAL SOCIETY OF ALLIED HEALTH
ANNUAL MEETING
MARCH 29-30, 1985

TABLE OF CONTENTS

I. CONFERENCE OVERVIEW

Harry E. Douglas, III, D.P.A. 1
Dean, School of Allied Health
Charles R. Drew Postgraduate Medical School
Los Angeles, CA

II. KEYNOTE ADDRESS

"Perspectives on the Health Status of Black Americans"

Thomas E. Malone, Ph.D. 4
Deputy Director
National Institutes of Health
Bethesda, MD

III. RESPONSE TO KEYNOTE ADDRESS

Harley E. Flack, Ph.D., Dean 13
College of Allied Health Sciences
Howard University
Washington, D.C.

IV. DONALD WATSON MEMORIAL LUNCHEON

Speaker:

Louis Stokes, U.S. Congressman 17
21st Congressional District of Ohio, and
President, Congressional Black Caucus Foundation
U.S. House of Representatives
Washington, D.C.

V. "COMMUNITY, CONSUMER AND RELIGIOUS PERSPECTIVES"

Community:

Richard D. Ford, M.S.W., Dean
School of Health and Social Work
California State University at Fresno
Fresno, CA

Table of Contents

		Page
V.	"COMMUNITY, CONSUMER AND RELIGIOUS PERSPECTIVES" (CONT'D)	
	Consumer:	
	Thelma R. Clemons, M.A. Retired Teacher Chesapeake, VA	31
	Religious:	
	Donald Taylor, Sc.D., Dean School of Health Related Professions and Natural Sciences Norfolk State University Norfolk, VA	35
VI.	"BUSINESS, EDUCATION AND PROFESSIONAL PERSPECTIVES"	
	Business:	
	Mary Redd, B.S., Executive Director Urban League of Tidewater, Virginia Norfolk, VA	41
	Education:	
	Primus Wheeler, Jr., M.S.P., R.R.T. Chairman and Assistant Professor Department of Respiratory Therapy School of Health Related Professions University of Mississippi Medical Center Jackson, Mississippi	43
	Professional:	
	Jane E. Jackson, M.D. Psychiatric Resident Department of Psychiatry Howard University Hospital Washington, D.C.	48
VII.	"RESEARCH AND POLITICAL PERSPECTIVES"	
	Research:	
	Fred McKinney, Ph.D. Heller Graduate School Brandeis University Waltham, Mass	53

Table of Contents

		Page
VII.	RESEARCH AND POLITICAL PERSPECTIVES (CONT'D)	
	Mitchell F. Rice, Ph.D. Associate Professor Department of Political Science Southwest Texas University San Marcos, TX	73
	Political:	
	Gloria G. Lawlah, M.A.T., Member Democratic Central Committee of Prince George's County, MD	92
VIII.	SEMINAR	
	"Health Promotion/Disease Prevention in Medically Underserved Areas"	
	Mary A. Moore, M.D. Western Tidewater Area Health Education Center Chesapeake, VA	95
	Deirdre M. Chatman, M.P.H. Charles R. Drew Area Health Education Center Los Angeles, CA	97
	Billie T. Sheppard, M.S.P.H. Project Director, Health Promotion/Disease Prevention Program College of Allied Health Sciences Howard University Washington, D.C.	101
	Don Combs, Ph.D. Peninsula Area Health Education Center Hampton, VA	103
	Donzella Lee, M.P.H. Watts Health Foundation Los Angeles, CA	108
IX.	HIGHLIGHTS OF CONCURRENT SESSIONS AND SPECIAL INTEREST GROUPS	
	Deans and Directors of Allied Health	
	Andrew Bond, Ph.D., Dean, School of Health Related Professions Tennessee State University/Meharry Medical College Nashville, TN	112

Table of Contents — Page

Allied Health Practitioners, Clinicians and Community Health Workers

Lucille Hickman, B.S., R.P.T. 114
Instructor, Physical Therapy Program
College of Allied Health
Chicago State University
Chicago, ILL

Department Chairs, Program Directors and Coordinators

Catherine L. Tolson, 116
Program Director, Medical Technology
School of Nursing and Allied Health
Tuskegee Institute, Alabama

Faculty

Dr. Lillie R. Williams 118
Chairperson, Department of Dietetics
College of Allied Health Sciences
Howard University
Washington, D.C.

Student

Arethea McClary, Vice President, Student Government, School of Health Related Professions and Natural Sciences 121
Norfolk State University
Norfolk, VA

X. THE PRESIDENTIAL ADDRESS

Harry E. Douglas, III, D.P.A., President 122
National Society of Allied Health

XI. CONTRIBUTORS 131

XII. LIST OF PARTICIPANTS 142

CONFERENCE OVERVIEW

NATIONAL SOCIETY OF ALLIED HEALTH

By

Harry E. Douglas, III, D.P.A.
Dean, School of Allied Health
Charles R. Drew Postgraduate Medical School
Los Angeles, California

Given the nature of health status of minority group members in America, particularly Black America, this report of the National Society of Allied Health meeting held in Virginia Beach, Virginia on March 29-30, 1985, was appropriate and timely. Indeed the theme "Partnerships in Health Promotion for Black Americans," evoked an enthusiastic response and high level quality participation. The meeting brought together some of our most talented health professionals to focus on an issue which has been widely discussed, but seldom placed into a conceptually discernible meaning structure.

One of the assumptions around which the meeting was designed was that a basic survival technique for neglected populations is to engage in cooperative collective action in the pursuit of socially purposeful objectives. The meeting, therefore, was organized on the premise that new forms and levels of partnership are necessary to positively impact and/or adequately address the social and environmental conditions adversely affecting the health status of minority group members.

Thus, the meeting focused on innovation in the context of humanism, equity and egalitarian issues. The primary concerns addressed research, education, employment and community service to promote the well-being of all Americans and improve the environmental conditions in which we live.

The meeting was formatted to examine health promotion from a broad societal perspective. Dr. Thomas Malone, Deputy Director, National Institutes of Health, set the tone for the meeting. His keynote address provided the conferees with a historical perspective of health care status of Black and other minorities in America. He advised that while improvement has occurred in the health status of Americans during the past 85 years, Black and other minorities remain far behind on a number of key health status indicators. Further, that the difference is primarily related to social, economic, and environmental variables. He stressed that "improving the health status of Black Americans will require an assault by every segment of our society, both public and private."

Dr. Malone was not disappointed for the meeting in fact addressed the issues of health promotion from every segment of our society. One segment dealt with health promotion from the community, consumer and religious perspectives. This section provided insights and models for improving health status and quality of life through a variety of mediating partnerships. The approaches focus on holistic insight, education, personal awareness and the historical need for Blacks to "pull together."

Another section focused on business, education and the professional perspectives. It was indicated that "the business community understand better than anyone else the benefits of establishing partnerships to promote health care." The motivation is tied to economic self-interest for both the business community and the minority health consumer. It was suggested that it is incumbent upon our education system and Health Professionals to provide leadership in terms of making these new partnerships an effective vehicle for improving the health status of minority group members.

The segment devoted to research and political perspectives stimulated a considerable amount of discussion. The research presentations by Drs.' McKinney and Rice provided information on the impact professional regulation has on minority employment in Allied Health and the Hill-Burton obligations to assure adequate health care to poor and rural persons. The real outcome of these sessions indicated that minorities should be more actively involved in health research. The political perspective was highlighted by the Donald Watson Memorial Luncheon address by Congressman Louis Stokes, who placed the health status issue of minorities into a action perspective. He advised that the reason for high infant mortality rates in Black America are well-known and that more studies are not needed but rather programs of action to close the health status gap along a number of dimensions and further, that the partnership approach to the promotion of improved health-status and quality of life should be a continuing objective of the National Society of Allied Health. Hence, praxis should be the "raison d' 'etat" for Educators, Allied Health professionals and Allied Health Associations in the policy making area concerning health care delivery to minority communities.

This report then captures the urgency and flavor of the meeting. It chronicles major strategies for improving the health status of Blacks and other disadvantaged groups. It is therefore timely in its content, appropriate in its focus, significant in its strategy, i.e., partnerships, and meaningful in its action agenda. It should therefore go a long way towards adding to the "praxis" process and serve as reference for Allied Health professionals and others who want not only

information regarding the health issues confronting minorities but want to help in closing the health status gap.

We thank Dr. Clay Simpson Jr., Director, Division of Disadvantaged Assistance, Bureau of Health Professions, U.S. Department of Health and Human Services for the support which enabled us to prepare a report of the meeting and Mr. Walter Levi, Project Officer, who supervised the contract.

Finally, we acknowledge the contributions and efforts of the many conference presenters, and especially Dr. Everlena Holmes and Dr. Algeania Freeman conference co-chairpersons, Business Services, Etc., Inc., and the Board of Directors of the National Society of Allied Health.

KEYNOTE ADDRESS

PERSPECTIVES ON THE HEALTH STATUS OF BLACK AMERICANS

Thomas E. Malone, Ph.D.
Deputy Director
National Institutes of Health
Bethesda, Maryland

It is a distinct and special privilege for me to participate in this annual meeting of the National Society of Allied Health (NSAH). It is a privilege because the agenda for this meeting tells me that this organization is serious about its commitment to improve the health status of ethnic minorities. I have always maintained that while we must depend upon others for some things, in the final analysis the responsibility to bring about change lies with us. I am impressed by your program which makes it abundantly clear that improving the health status of Black Americans will require an assault by every segment of our society, both public and private.

I want to speak for a few minutes on some "Perspectives on the Health Status of Black Americans." The perspective I want to emphasize is well illustrated by the story of a young college student who wrote her father towards the end of her first semester at a well known university.

"Dear Dad," she wrote, "I am sorry to tell you that I have had a few minor problems during my first month here. I fell in with a bad crowd and have become addicted to drugs. I forgot all the wonderful upbringing you and mom gave me and, as well, the teachings of the church. In fact, I am pregnant and living with the father-to-be of my child. I hope you and dear mother will find it in your heart to forgive me and I promise to do better in the future."

Your loving Daughter,
Cynthia

"P.S. Dad:
I am not on drugs.
I am not pregnant.
I am not living with a boy.
I have not strayed from the wonderful guidance I got at home and the church.

But, I did flunk mathematics and wanted you to see this from the perspective of other far worse possibilities. You see, flunking math isn't so bad, after all."

As a matter of perspective, I have to acknowledge that the overall health status of Americans has improved greatly since the turn of the century. While this is true in the aggregate, Blacks and other minorities suffer an alarming differential

which has its antecedents in a history known to all here. This differential in health status persists today in bold relief, yet progress has been made, and I would be remiss if I did not first remind you of this progress as a prelude and substratum for further progress.

Let me first go back to the beginning of this century when the New York Times sold for one cent in New York, when the practice of medicine was still in its infancy and the physician was essentially a spectator not able to really do very much about the disease process. Some diseases could be described but little was known about the mechanisms underlying the biology of the disease. As the Flexner report was to reveal a few years later, the preparation of professional manpower was for the most part grossly inadequate. In my home state of North Carolina, the University of North Carolina required a not strictly enforced year of college work for entrance and had a total teaching staff of 15 persons. A student could be admitted to the Leonard Medical School in Raleigh, North Carolina, with less than four years of high school.

It is no wonder that in 1900, the life expectancy for the total U.S. population at birth was 47.3 years. For Blacks, it was much lower--a shocking 33 years. For each 1000 live births, more than 100 infants were destined to die and Black infants were at greater risk. We had no vaccines, antiviral agents, or drugs to treat infectious and other diseases. Anesthesia was not very well developed and surgery had progressed only slightly from the Civil War days when a soldier with a severe leg wound would be subjected to amputation with a "swig" of whiskey and a dirty saw. One could add to this vignette the fact that the 20th Century ushered in the failure of Reconstruction and a deplorable state of racism that would only begin to be diminished 60 years later.

The Library of Congress reports 95 lynchings for 1902, no doubt a conservative number. Biomedical research was carried on only under individual initiative, with minimal or no support from public funds. Members of the profession you represent were practically nonexistent in 1900. There were less than two people in health care for every physician and these were not allied health professionals.

So we first have the perspective of what it was like just 85 years ago, not much time for a planet that is at least 5 billion years old. The second point of view that I want to emphasize might be captioned the "good news." It is simply this: In the short period of a little over three generations we have had some revolutionary changes healthwise. Due to improved sanitation, better nutrition, and control of

infectious diseases largely through immunization, the infectious diseases were brought under control.

Tuberculosis, gastrointestinal diseases, diphtheria and polio, all combined will take less than 10,000 lives this year. Without the progress made since the early 1900's, we could have expected this year almost 400,000 Americans to lose their lives to tuberculosis, 300,000 to gastrointestinal diseases, 80,000 to diphtheria, and 55,000 to polio. Through a monumental effort of member countries of the World Health Organization, smallpox, a disease that maimed, blinded and killed millions of people throughout history, has been erased from the face of the earth.

In the short period of a little over three generations, we have established in this country the most remarkable, largest and most productive biomedical research establishment the world has ever known. Through this national effort we have acquired unprecedented knowledge about life processes in both the normal and diseased states. We have placed into the hands of the physician powerful medications, instruments of diagnosis, and treatment modalities that were not dreamed of in 1900.

We have broken the genetic code and recombinant DNA technology, a tool that in biology parallels the discovery of atomic fission in physics, offers mind-boggling possibilities for genetic engineering. Gene therapy is just around the corner and the doctor's black bag in the year 2000 will be full of devices for treating disease at the molecular level. In a short while, we will know how to shut off a cell that has become cancerous, and we will know the secrets of those nearly thousand billion cells that comprise the brain. The accomplishments are truly phenomenal.

The ultimate perspective is that despite this unprecedented explosion in knowledge, the ascending power of science, and the increased capacity of medicine to diagnose, treat, and cure disease, Blacks and other minorities have not benefited fully or equitably from the fruits of science. In releasing the report, Health United States, 1983, Secretary Heckler reviewed our gains but was distressed by the persisting disparities between the White and Black populations. The report showed that:

-- the life expectancy for Whites is 75.1 years and 69.3 years for Blacks;

-- the infant mortality rate for Blacks is twice that of Whites;

-- Black people under 65 years of age are more likely than Whites of the same age to have no health

insurance of any type;

-- Blacks continue to use the health care system less;

-- despite notable gains, hypertension is still more prevalent in the Black population.

The list went on and on to show that Blacks have poorer health in practically every health index. Reviewing these and other statistics, Secretary Heckler decided to establish a Task Force to review the disparities and to make recommendations to her that, when implemented, would help close the gaps. I reluctantly agreed to Chair the Task Force, and would like to briefly tell you where we are without preempting the final report which is in preparation now.

The charge to this Task Force was delivered in person by Secretary Heckler. We were asked to:

1. review the current health status of minorities as well as their access to and utilization of health care;

2. assess factors contributing to the long-time disparities;

3. evaluate existing Federal research and service programs relative to minority health;

4. examine issues identified by state and local governments and the private sector that affect the health status of minorities;

5. develop recommendations from which Federal resources and programs can be redirected to narrow the "gap";

6. suggest ways in which the public and private sectors cooperatively can effect improvements in minority health.

These charges constituted a challenge of unusual dimension and our first task was to select a Task Force equal to the challenge. The individuals appointed to the Task Force are therefore senior officials with programmatic authorities in areas of concern. The Task Force has had at its disposal the resources of the entire Department, including the services of a very competent staff drawn from a number of departmental agencies.

In order to develop recommendations that would impact on the disparity, the Task Force, from the beginning, decided that it must develop exacting definitions of issues and minority

groups and make careful analysis of etiology and influences. The study design adopted by the committee, therefore, focuses on three questions:

1. What is the extent of the health status disparity between minorities and the majority populations?

2. Why does the disparity exist?

3. What can be done to narrow the gap?

The first problem facing the Task Force was to delineate the dimensions of its task. After all, there were literally hundreds of conditions, issues, and diseases that could be studied, but obviously not in the time frame of one year. There was also lots of available data and statistics which pointed to differences in health status. The Task Force, to be absolutely certain of those conditions that were most significant in causing health disparities, decided upon a methodology suggested by Dr. Al Haynes, Dean, Drew Postgraduate Medical School in Los Angeles. This method views the disparity on the basis of "Excess Deaths," i.e., the death burden of minorities which is in excess of the rate for the White population.

Excess deaths were calculated by applying the White death rate to the minority population at risk to derive an expected number of deaths, then subtracting this from the actual deaths that occurred, by age, sex, and cause. Only excess deaths up to age 70 were examined. Similarly, person years of life lost was calculated up to age 70 by multiplying the number of excess deaths that occurred at each age by the difference in that age and 70. Life expectancy was also used and is a technique taking into account the death rates at different ages in the population at risk which measures the number of years one is expected to survive from a given age, usually at birth (age 0).

Using death certificate data, the Task Force calculated the minority group's mortality from over 40 diseases and compared these figures to what the mortality would have been if their death rates were equal to those of the White population. I do not want to bore you with these data but some may be worth repeating here because they served as the basis for further study of the Task Force.

For the years 1979-1981, excess deaths prior to age 70 for Black men and women totalled almost 59,000 or 42.5 percent of all deaths prior to age 70. In 1969-71, excess deaths totalled almost 73,000 or 46.6 percent of all deaths prior to age 70. There was thus some improvement in the excess death index between these two data points, i.e., over a 10 year

period. The person years of life lost prior to age 70 show that 2.1 million person years of life among Blacks were lost in 1969-71, while in 1979-81, 1.5 million person years of life were lost. What an enormous waste of life!

What were the causes of these excess deaths? The answers were not surprising. For males, in 1979-81, cardiovascular disease (heart disease plus stroke) caused the highest number of excess deaths (8,460), homicide was next (6,708), then cancer (5,834 excess deaths), infant mortality (3,317), accidents (2,261), cirrhosis (1,372) and diabetes (646). For females, the order was cardiovascular disease (9,712), infant mortality (2,861), cancer (2,284), homicide (1,381), diabetes (1,204), cirrhosis (782), and accidents (559) (Table 1).

The leading causes of person years of life lost prior to age 70 were equally dramatic. The leading causes of the loss in 1969-71 were infant mortality, homicide, accidents, heart disease, and stroke for men and infant mortality, heart disease, stroke, accidents and homicide for women, in that order. In 1979-81 the leading causes of lost person-years of life for men were infant mortality and homicide, but heart disease and cancer moved ahead of accidents as the five primary contributors. For women, infant mortality, heart disease, homicide, cancer and stroke rank as the leaders in the disparity in person years lost in 1979-81. The relative rise in cancer over the decade for both Black men and women should be considered alarming.

We found that the relative risk of death for almost every cause examined was shockingly large for Blacks under 45. The risk of death from all causes for Blacks under 45 is almost twice that of Whites. Homicide was the leading cause of death for Black males of ages 15 to 44. In 1980, the homicide rate for this group was 84.2 deaths per 100,000 population compared with 15.2 per 100,000 for Whites. Over the decade of our review, homicide in Black males and females has increased.

Early in its deliberations the Task Force decided to zero in on these areas that accounted for more than 80 percent of the disparity in health status between Blacks and Whites. Six subcommittees were established to focus on the three questions I posed earlier: What is the extent of the disparity? Why does it exist? And what can be done about it? Each subcommittee has submitted its final report to the Task Force and they are being reviewed along with potential recommendations. The reports cover in great detail the physiologic, psychosocial, societal and cultural factors leading to the excess death or injury along with preventive interventions. In addition to reviewing existing data and the

TABLE 1: Excess Deaths in the Black Population by Sex and Cause, 1969-71 and 1979-81.

MALES

	1969-71		1979-81	
Disease	0-45	0-70	0-45	0-70
All causes	20,845	39,925	14,726	35,321
Cancer	373	3,674	435	5,834
Diabetes	156	696	116	646
Heart disease	1,512	4,257	1,446	5,633
Stroke	633	4,202	450	2,836
Accidents	2,536	3,288	1,089	2,261
Suicide	5,165	6,496	5,468	6,708
Cirrhosis	796	1,205	702	1,372
Infant mortality	5,145	5,145	3,317	3,317

FEMALES

	1969-71		1979-81	
	0-45	0-70	0-45	0-70
All causes	12,992	32,895	8,210	23,621
Cancer	529	2,175	439	2,284
Diabetes	172	1,692	107	1,204
Heart disease	1,479	8,899	1,054	7,235
Stroke	685	4,566	362	2,477
Accidents	882	1,159	339	559
Suicide	1,095	1,347	1,145	1,381
Cirrhosis	576	863	419	782
Infant mortality	4,260	4,260	2,861	2,861

Excess deaths - (actual deaths - expected deaths), where expected deaths = (white death rate x black population).

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literature, expert consultants have been used. Indeed, more than 50 papers were commissioned by the Task Force for use by the Subcommittees and Task Groups.

Just to give you a glimpse of a typical report, the Subcommittee on Cancer has produced a definitive three-volume work describing the cancer experience of U.S. Blacks and other ethnic minorities, based on the currently available data. It graphically details the fact that Blacks have the highest overall rates of cancer incidence and cancer mortality of any U.S. population. The report discusses what types of cancers are more prevalent in the Black population (lung, esophagus, stomach, pancreas, cervix, and corpus uteri) and risk factors that appear to cause some of these cancers. In the case of lung cancer, for example, Black males have a 45 percent excess death rate compared to White males. The report states flatly that 90 percent of lung cancer deaths are related to cigarette smoking; cancer of the esophagus to alcohol and tobacco use; stomach cancer to tobacco, alcohol and dietary intake of salty foods and those high in n-nitroso compounds. Causes of the other types of cancers are not known although some risk factors are suggested including occupational exposures. The report reveals that the overall 5-year survival for cancer for Blacks was 12 percentage points below that of Whites. Of the 25 primary cancer sites for which survival data were available, Blacks had lower survival rates for all but three cancer sites--ovary, brain, and multiple myeloma, all cancers with relatively low incidence and low survival in all groups.

The report presents preliminary data to show that these differences in survival status between Blacks and Whites seem to be based upon socioeconomic status affects access to health services, nutritional status, immune status and function, educational level and employment status, and attitudes, awareness, and practices. Furthermore, social or natural environmental factors either cause the majority of cancers or promote their development. I would not be surprised if some of the recommendations from the cancer report do not focus on measures which we can take to reduce this blight through preventive measures at the community level, in the home and in the workplace.

The Task Force did not restrict itself to the six disease entities. We will have reports and recommendations in the additional areas of health information and education; access, utilization and financing of health care; health professions development; leadership and capacity building in the non-federal section; data development; and research. We have additionally sought information and advice from more than 300 organizations and groups in the non-federal sector. The results of this survey are being carefully reviewed and will be incorporated into the fabric of the final report.

Finally, the Task Force has made an inventory of every program in the Department of Health and Human Services that impacts on minority health. This compendium will be an important source document as we examine programs that may be redirected to impact on this national problem. The Task Force and staff are working mightily to have a draft report to Secretary Heckler by late Spring. At this point, I feel confident that she will be receiving a landmark document.

The history and objectives of the NSAH brings into sharp focus several facts that the Task Force has recognized from its inception. We are patently aware that NSAH has been working to improve the health status of minorities since its beginning. The Task Force I chair is the "new kid on the block." We know, that your membership has been working at the grass roots level. We know, and would be naive to believe otherwise, that if the disparities are to be erased, government, the private sector, state and local governments, professional organizations like NSAH, religious groups, and ordinary citizens must all share in addressing the problem and in making a difference. We need a cooperative venture--a national assault--of a dimension never before imagined. The Task Force looks forward to working with NSAH to achieve our common objectives.

RESPONSE TO KEYNOTE ADDRESS

Harley E. Flack, Ph.D., Dean
College of Allied Health Sciences
Howard University
Washington, D.C.

My first response in terms of hearing Dr. Malone's address is to once again thank him for such a very fine presentation. We have an awful lot to think about and to work on and again I would just like to thank Dr. Malone for that very fine address.

In listening to Dr. Malone's address I felt somewhat like a student, because I was busily taking notes and trying to synthesize the words that he was giving us, but there was so much that was in his keynote address that I am sure I only grasped a very small portion of what is there. I am sure that you in your own way will analyze and synthesize the information and ideas that he is sharing. However, in listening and trying to outline this response, there were about six things that I heard in Dr. Malone's address that I would like to respond to.

The first thing that he gave us is a historical perspective of the health care status of Blacks and other minorities in this country. He gave us some statistics about what was going on approximately 85 years ago at about the turn of the century with regard to the health care status and the participation of Blacks and other minorities in the health care delivery system of this country. He mentioned very briefly one report that I had read years ago, which was the Flexner Report of 1910. I believe there were actually two of them; the first, I think, was in 1910. One of the things that I always reflect upon in terms of that report was that in 1910, there were six Black medical schools, not the four that we have today. One of the things that I have to reflect on is what happened to our efforts in terms of training health manpower, health professions and health care delivery. Also, in that Flexner Report, as I reflected, the volume that Dr. Flexner produced was a rather thick volume, there is only about one-half page or one-third page that is devoted to a discussion of the health care status and concerns of minority people. So, certainly the report and the activities that Dr. Malone gave to us indicate that we have come a long way in terms of recognizing the importance and the concerns of Blacks and other minorities in the health care system of this country. Also, in the Flexner Report there was no mention of Allied Health Professionals nor Allied Health Professions because there were none at that time, except for, perhaps, nursing. The Flexner Report was in part responsible for the emphasis on

specialization in health care delivery which developed, and out of the specialization grew the Allied Health Professions.

The second point that I heard Dr. Malone deliver to us was that there was some good news in terms of the general health care status and improvement of Blacks and other persons in this country as we look at the statistics of what happened from the turn of the century to 1985. He gave us a number of statistics that depict graphically and statistically the improvements that were made in a number of conditions. However, again, his bottom line was that Blacks and other minorities did not benefit from those changes in the general health care status of Black Americans. I should also point out that during the period of time that Allied Health Professions came to life, there were a number of different health care fields that were developed in response to the specialization in health manpower development. I would like to say, paralleling Dr. Malone's observation, that Blacks and other minorities did not benefit from the development of the Allied Health Professions from the 1920's through the 1980's. We know from the statistics regarding minority representation in allied health that we are vastly underrepresented in those professions that have so much to do with the conditions which he pointed out affect Blacks and other minorities so adversely.

The third point that Dr. Malone made related to the findings of the 1983 Report On The Health of Black Americans, out of which the Task Force was appointed. The bottom line there was, as I heard it, that 85 years later, Blacks are still far behind with regard to a number of key health care concerns.

The fourth point that I heard Dr. Malone give us related to some of the actual findings from the Task Force report. He gave us the charge that had been given to the Task Force by Secretary Heckler and some of the activities engaged in by the Task Force in response to that charge. He outlined some of the findings of the Task Force. One of the key findings he indicated was a new dialogue through this Task Force activitity that has been established. And this dialogue was important in establishing a discussion on the key issues which affect Black Americans. Certainly, we in Allied Health would like to believe that we are a very important part of that dialogue and will continue to be a part of that dialogue in the years to come. We need to be involved in that partnership as the theme for our program states so vividly. Some other outcomes from the Task Force report were the statistical manipulations that were performed on the data, research design and methodology, for some of us who are interested, (and hopefully we will become more interested in research) that there were some new methodologies that we perhaps can look at for our future research activities. He pointed out the notion

of looking at excess deaths, which I think is unique, as an important way to look at health care status of Blacks. He also pointed out looking at the person's years of life that were lost as another way of assessing the health care status of Black Americans. He went on to point out specific comparisons between Blacks and Whites, comparisons and contrasts between Black males and Black females with regard to the six leading causes of death, which he indicated accounted for approximately 80 percent of the excess deaths among the Black population.

One of the bottom lines of all of the data he reported on is that many of the differences in the excess deaths in the person's years of life lost among Black Americans is related to socioeconomic variables, that some of the effects also have to do with the lack of access, utilization, the poor condition with regard to financing health care among Black Americans and, of course, the participation of Blacks and other minorities in the health care delivery that has so much to do with improving the health care status of Blacks and other minority individuals. Again, as we reflect on that, there is so much that we need to do in terms of Allied Health's involvement in health care delivery. He talked about the effects of smoking, dietary habits and other conditions and again, we as Allied Health Professionals in our nutrition programs have a lot to do, a lot to contribute to improving and turning those statistics around.

I do hope, as a fifth point, Dr. Malone, that we, the NSAH, were included, or will be included among the 300 organizations surveyed with regard to expressing our opinions and our views as to what needs to be done in this new partnership toward improving the health care status of Black Americans. I would like to point out that we in Allied Health represent the largest segment of the health care delivery force. I know there are some 3.5 million or more allied health care workers and providers, and we represent the largest group of health care providers that are functioning in this country. We hope that we at the National Society of Allied Health, and as one of the chief spokespersons or spokesgroups for the Allied Health Professions, will have an opportunity to respond to your survey.

Finally, it was instructive and insightful to hear some history and some background on the acronym that stands for the National Society of Allied Health. We have tried over the years to come up with one, and you gave it to us in terms of an interpretation that is NSAH (en-sah) as I think you referred to it.

NSAH in Arabic stands for the word forgotten, and we are pleased to say that we feel that we of the National Society represent and wish to speak for and with those forgotten persons throughout the world, the Blacks and other minorities.

In closing, I am very pleased and have been enlightened, invigorated, and motivated by your Keynote Address, Dr. Malone, which sets the tone for us to have a successful and productive meeting.

DONALD WATSON MEMORIAL LUNCHEON:

Louis Stokes, U.S. Congressman
21st Congressional District of Ohio, and
President, Congressional Black Caucus Foundation
U.S. House of Representatives
Washington, D.C.

First, let me say to all of you that it is indeed a great honor to have been invited here and afforded the opportunity to share this special occasion with all of you. I am particularly honored because Donald Watson, in whose name you nave this luncheon today, happened to be one of our most revered members of the Congressional Black Caucus Health Brain Trust. He co-chaired the Health Brain Trust meetings in 1977 which were held in Washington, D.C.; and for all of you who knew him, I am sure you share with me a very special memory of this talented and dedicated man who left us in the prime of his life. And so I deem it a real honor to participate in the honor you pay his memory today.

I am delighted this afternoon to speak to you on a subject that I live and work with everyday. That subject is the appalling health status of Blacks and other minorities in a nation that has the most sophisticated health care delivery system in the world. From my vantage point as a United States Congressman, it is disturbing to see what is happening in and to our nation's system of health delivery. America is moving backwards to an onerous two-tiered health system, one for the rich, one for the poor, a two-tiered health system that we worked so hard to erase during the great war on poverty of the sixties during the era when America saw that people were starving, that we needed doctors, that poor people needed financial help to obtain medical care, and we did something about it. A major response was the enactment of the Medicaid and Medicare programs, probably two of the greatest achievements in health care that this nation has ever accomplished. Since the implementation of these two programs, great strides have been achieved in improving the availability and the accessibility of high quality health care regardless of a person's ability to pay for that care. But now I see these significant gains fast slipping away. Poverty in America is at its highest level since 1965. Yet the national mood is not about a war on poverty, but about arming for war with other nations. Just yesterday the Congress passed in the House, a bill that put 1.5 billion dollars into 21 new and additional MX missile sites. At the same time, according to recent study by the Center on Budget and Public Priorities entitled, Falling Behind, a report on how Blacks have fared under the Reagan policies, it told us that nearly 36 percent of all Blacks lived in poverty in 1983, the highest Black poverty rate since the Census Bureau began collecting data on

black poverty in 1966; and from 1980 to 1983, an additional 1.3 million Blacks became poor.

The national mood in our country has changed; and in 1985 the most damaging indictment about our health priorities is that we have common instances of mothers who cannot obtain needed medical care for their babies at a time when our nation is accomplishing breath-taking feats in the medical arena. Now we all know what can be accomplished in medicine is really mind-boggling. Technical advances in medical care are now tumbling forth faster than we can absorb their significance. We can now keep people alive through artificial hearts and through computers. We can help paraplegics walk when only just a few years ago, no one even dreamed that this could happen. Medical research has given us vaccines. Antibiotics have wiped out or controlled many diseases which once killed or crippled people. Yet we also know that technical breakthroughs in medicine are hardly enough, perhaps necessary, but not sufficient to ensure state of the art medical care to all who desire it. We know the disturbing gaps in health status between minority and White populations persists, and that they are now widened. We know that minorities suffer disproportionately from poor health.

The latest official statistics tell us, and I quote, "Black males can expect to live six fewer years than White males, 69.6 years compared to 75.2 years for Whites. One of every four Blacks has high blood pressure, compared to one of every seven Whites. Moreover, the hypertension rate among Black Americans is reported to be nearly twice the overall national rate, or as high as 20 percent of the Black American population. Cancer mortality rates for Blacks have increased by 26 percent over the past 25 years. For Whites that increase has been 5 percent. The excess in rates of cancer deaths has been especially notable in cancers of the stomach, esophagus, prostate and uterus. Minority mothers die in childbirth three times as often; and of those who do survive, one in forty must then watch her baby die in the first year of life."

The Health Sub-Committee on which I sit corroborates this appalling fact. Witnesses appearing on behalf of the National Institute of Child Health and Human Development told us that, "We still have a long way to go toward reducing the infant mortality rate. The infant mortality rate has been cut by more than half in this country during the past two decades. Nonetheless, 11 countries have a lower rate. The rate among Blacks is still double that among Whites, and the rate of low birth weights has not changed. As for opportunity of our 3.6 million infants born each year, nearly 40,000 die before their first birthday; 250,000 face an increased likelihood of handicap as a consequence of low birth weight. Three percent

have a significant congenital anomaly. Another three percent are mentally retarded, and approximatley half will need medical treatment for serious injury during childhood, often with lasting physical or mental consequence."

Recently, Health and Human Services Secretary Margaret Heckler released a report entitled, "Health, United States 1984." This is the Annual Report on the nation's health status. As in previous years, the government's Annual Health Report continues to emphasize the critical level of Black infant mortality in America. You may recall that last year upon releasing "Health, United States Report," Secretary Heckler announced that she would create a special task force to spend a year studying why such a wide disparity in infant mortality rates and other health problems exists between Blacks and Whites. No one in the Administration questioned the wisdom of the Secretary's decision to conduct an additional study on infant mortality, or even mentioned the voluminous research on the causes of infant mortality that has been conducted or funded over the past 20 years. There are many health problems whose cause and cure are unknown. Infant mortality is not one of those. We know that infant deaths are due to the large number of American babies weighing under 5-1/2 pounds at birth. Two-thirds of infant deaths occur during the first month of life, and about half of all deaths in the first year result from low birth weight. Black infants are about twice as likely to be born underweight as White babies. In the District of Columbia, where nearly 70 percent of the population is Black, the incidence of low birth weight is a staggering 50 percent above the national average. Moreover, numerous studies sponsored by Secretary Heckler in her own Department have shown that low birth weight and infant deaths can be reduced when pregnant women receive adequate prenatal care. For example, babies born to women who receive late or no prenatal care are three times as likely to die in infancy as those born to women who receive adequate health care. Recently, the Institute of Medicine Committee to study low birth weight issued a report which strongly reinforces this very point. After two years of careful and deliberate study, the Committee concluded that comprehensive prenatal care would reduce the incidence of low birth weight by 50 percent. Moreover, the Committee's findings on the value of prenatal care are strong enough to support a broad national commitment to ensuring that all pregnant women in the United States, especially those who are medical socioeconomic risks, receive high quality prenatal care services.

So the problem is not unknown facts, but inaction. Black babies are more likely to die because Black mothers are more likely to be poor and simply cannot afford the prenatal care that would help solve the problem.

As I mentioned earlier, it has been a year since the creation of the Task Force on Black and Minority Health. The one good thing about the creation of that particular task force was the fact that Dr. Malone, who is here today, chairs that particular task force. In addition to mortality, there are some other significant areas where I think studies have to be done. But my particular qualm or problem with Dr. Heckler's approach toward the whole matter was the fact that infant mortality is one area where with one more year of study, many more children will die while we are studying the problem instead of implementing some type of action.

Recently at our hearings I did question both Secretary Heckler and Dr. Malone, both of whom have now assured me that not only would the report be forthcoming very shortly, but she assures me that once Dr. Malone and his task force have delivered that report to the nation, that some type of action will be taken. I did start out with the position that the one thing Black people are tired of is being studied. If there is any group of people in America who have been studied, we have been studied.

Unfortunately, providing needed health care for poor Black babies and mothers has not been a very high priority in our nation. There was a time when this country was committed to principles of social justice and welfare. Just six short years ago in Congress raging debates were taking place on making health care a right, not simply a privilege, for all Americans through a system of national health insurance. Now the pendulum has swung the other way. Few people care nowadays about extending individual rights to health care; but instead, it is cost containment. We are no longer concerned about an adequate supply of doctors, nurses and other health professionals; instead, we are talking about having too many. Congress is now debating the 200 billing dollar deficit and how to cut health care spending. The current wisdom is that we cannot afford to provide costly health care to all, and ethicists now debate the moral dilemma of rationing health care. Put simply, as a nation, we have now become less concerned about people. We have become a nation more preoccupied with playing star wars in space, and no longer committed to a war here on earth on poverty. The conservative political and social mood of this nation combined with the troubled state of our economy has resulted in national policies and legislation that can only be labeled as hazardous to the health of minorities and poor Americans.

The current administration would have you believe that the primary role for the federal government in health care these days is to cut costs, not to promote health. Never mind the fact that in health care we save money in the long term, by spending money in the short term to prevent illness and

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sickness. The President's proposed budget is a primary example of this misguided philosophy.

Last month President Reagan submitted his Fiscal Year 1986 Budget to Congress. As in the past, the President's Fiscal Year 1986 Budget Proposal simply demonstrates one man's remarkable knack for formulating an infinite number of ways to work deficit reduction magic at the expense of minorities and the poor. This year, the Medicaid program is expected to provide services for nearly 24 million persons, including 11 million children. For these individuals, the Medicaid Program is the only way to pay for check-ups, medical treatment, dental care, hospitalization and needed drugs. Additionally, for several hundred thousand pregnant women, the program pays for prenatal and delivery services. Still half of the poor people in America are ineligible for Medicaid and thus lack the resources to pay for costly health care. Instead of expanding the program to reach these needy individuals, the President's budget proposes to reduce Medicaid payments by 1.1 billion dollars. That is about the same amount we put yesterday in MX missiles, by placing a cap on federal Medicaid payments to states. For Fiscal Years 1986-1988, the President expects to reduce federal spending in the Medicaid Program by 6.5 billion dollars. The proposed Medicaid funding cap would allow program growth of only 3 percent less than half the medical care inflation rate and essentially a cutback in funding level. States would either have to make up these cuts out of their own budgets or cut their programs.

Local child health centers and community health centers are two examples of programs that would greatly improve the health of minorities and the poor in their own community. In the past few years, neither has been adequately supported by the Federal government. Since President Reagan took office, cuts in essential health programs such as community health centers, maternal and child health programs, sickle cell clinics and community mental health centers have made it even harder for minorities and low income Americans to gain access to the health care that they need. Over 100 community health centers have been terminated from federal support eliminating 400,000 mostly poor persons from services. Funding for prenatal care, immunizations and check-ups for mothers and children, preventive maternal and child health services has been lost. Moreover, thousands of nutritionally at risk mothers and infants are on waiting lists to receive milk and other food supplements under the WIC Program, which President Reagan wanted to consolidate into a block grant. Federal support for community mental health centers has been consolidated into a block grant with overall funding reduced by 30 percent. Not only has the President's budget policies cut health programs, they have also made it virtually impossible for many disadvantaged and minority students to pursue careers in

health. This Administration would have you believe that our nation has too many health professionals and has made repeated efforts to terminate federal support for training health personnel.

In spite of past congressional objections to his health manpower policies, the President has proposed to completely eliminate federal financial aid in Fiscal Year 1986 for students pursuing careers in the health professions. The continuation of health education is particularly important to well qualified, disadvantaged and minority students who would otherwise be denied this opportunity simply because they lack the necessary fiscal resources. For many of our young people, poor minority students, federal health education and training programs have been the key to the door of equal opportunity in health careers. Now because we have seen every day occurrences where inner city and rural community poor residents cannot obtain the services of a doctor or nurse and do not have access to adequate trained mental health professionals, if we take a look at minority representation in allied health, we see that Blacks remain substantially under-represented. While Blacks represent nearly 12 percent of the United States population, the percentage of dental hygienists is a pitiful 2 percent; only 4 percent of the dental assistants are Black; out of 145,000 pharmacists, only 3 percent are Black; and of over 20,000 occupational therapists, only 4 percent are Black. This in and of itself continues to represent a major barrier to providing adequate health care in our nation.

I consider it a national disgrace that there has been little or no improvement in these figures, when at the same time there has been a tremendous growth overall in the number of students being trained for service in the health industry. Minority representation in these and other health fields is at such miniscule levels that they will never significantly improve without federal aid to students and financial incentives to institutions. Because Black health personnel in predominately Black health profession schools are needed to address the severe unmet health care needs of our poor and minoirty citizens, we face a philosophical and ethical dilemma. Either we provide the financial and other resources needed to implement our nations creed of equal opportunity, or we abandon a large segment of our population to high infant mortality, shortened life expectancy, debilitating poverty, a crushing burden of illness and disability, and increasing disillusionment, frustration and loss of hope. As the most affluent of nations, and the leader of the free world, we should not allow this to happen.

During the past session of Congress, I introduced HR-5503 the Health Professions Minority Training Assistance Act of 1984.

This bill is a modest and sound proposal which seeks to address the current critical national shortage of minorities in the health professions. Specifically, the legislation serves to increase minority student financial assistance, strengthen the endowment and financial base of minority institutions, and develop and encourage minority faculty recruitment and training. Congress did pass the legislation, which included several of the provisions that were in my bill. Unfortunately, President Reagan pocket vetoed the legislation and all of our work went for naught. However, I do intend to reintroduce this bill in this session of the Congress.

What I think we need is a more concentrated effort on our part -- the National Society of Allied Health, the Association of Minority Health Profession Schools, the Congressional Black Caucus Health Brain Trust -- all of us need to join in some type of partnership to assure a stronger voice in support of this type of legislation.

Lastly, I should mention to you something that Dr. Harley Flack has mentioned to you; and that was I worked with NIH, with Dr. Malone and others at that institution to create a special initiative. One of the reports that I had requested from NIH showed that out of a 4 billion dollar research budget that was given to an institution by the Committee on which I sit, only about 27 million dollars, or less than 1 percent goes to Black colleges. And so as a consequence of working with Dr. Malone and others, we have now passed into Congress and created a bold new initiative in which we now have five million dollars for the first year, which is to set up special core research centers at minority institutions that will have the responsibility of doing special research in the areas of dealing with these differentials between Blacks and White health care.

I will end today by saying to you that we need more active participation by educators, allied health professionals, and allied health professional associations in the policymaking area concerning health care delivery to minority communities. This would almost certainly lead to a greater focus on the need to assure equal educational opportunity for all who wish to pursue careers in allied health and other health disciplines. All of you who are in this room today are uniquely suited to spearhead this type of partnership. You can help to educate the public at large and the Congress about the need to invest more of America's resources toward the training of minority allied health personnel. The challenge facing us is immense for political action, education and the development of creative solutions. We must continue to fight for health care as a right and not as a privilege. I look forward to working with you in influencing health and social welfare policies at the national level and the achievement of

desirable and just goals of a healthy Black community and the development of accessible, efficient and effective health care resources.

PARTNERSHIPS IN HEALTH PROMOTION FOR BLACK AMERICANS FROM A COMMUNITY PERSPECTIVE

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We are witnessing a crescendo of interest in health promotion today. Over the past decade this interest has resulted in expanding research efforts and public expressions. There has been an overwhelming response from a large segment of our population, and this response has developed into personal involvement in health promotion and disease prevention. The Federal Government, as we heard this morning, has recently given impetus to the continual development of this area, and we are beginning to see at least some of the amount shifting from biomedical technology into health promotion and disease prevention. The Office of Health Information/Health Promotion established a few years ago, has recently been changed to Health Promotion, Physical Fitness and Sports Medicine. The Center for Health Promotion and Education has become an integral part of the Center for Disease Control. Two national studies on this subject have been published in the last five years: Healthy People, The Surgeon General's Report, and a follow-up study, Promoting Health, Preventing Disease: Objectives of the Nation.

There are also things happening in the private sector: a San Francisco-based National Center for Health Education; a Washington-based Advisory Committee on Education for Health, sponsored by the insurance companies; and there are literally thousands of small local and community efforts with regard to increased public awareness in the area of health education and promotion.

he continuing call for more illness care begs the fact that our most improved health has come from disease prevention, rather than therapeutic intervention in the disease process. Evidence strongly suggests that the greatest improvement in America's health has come from better housing and food, sanitation, water purification, sewage disposal and food processing. And, over a generation of efforts have concluded that the four major determinants to an individual's health in today's society are lifestyle, environment, heredity, and lastly, medical care through the medical care system. Lifestyle accounts for about 53 percent; environment, 21 percent; heredity, 16 percent; and the intervention of the

health care delivery systems for only about 10 percent. There is, of course, an interaction among these four types of individual behavior; and lifestyle is the most markedly affected. Human behavior is affected by contact with all four of these elements; and one must add intellectual, social and spiritual well-being. The major causes of death: heart diseases, cancer, accidents, motor vehicle accidents, cirrhosis of the liver, and suicide, are all related to lifestyle, social and spiritual factors.

A number of the most current studies and one major study taking place in California indicated that of these major causes of death, one can factor out the major contributors, using basically the four groups -- lifestyle, environment, heredity, and the health care system.

For example, we know that in relationship to heart disease, the health care system influences that for only about 12 percent; lifestyle, 54 percent; environment, 9 percent and heredity, 28 percent. Suicide, which you heard this morning was one of the leading causes of death among Blacks, particularly males, is affected by the health care system by only about 3 percent; lifestyle, 60 percent; environment, 35 percent; and heredity, 26 percent. Cancer is also a large leading cause of death among Blacks. The health care system affects it about 10 percent; lifestyle, 35 percent; environment, 24 percent; and heredity, 29 percent. So, the major factors in health determinants today are basically getting people to behave in ways to avoid some of the hazards around them, and not to provoke additional hazards. Therefore, one of the major focuses in terms of health promotion is looking at risk reduction or what has come to be called, in terms of a methodology, health hazard appraisals. There are basically two approaches as we try to formulate a philosophy in terms of our own work, health promotion for Black Americans. The micro approach is probably the most popular today in terms of the health promotion industry. It involves behavioral changes on the part of the individual. This approach will take several forms. Creative behavior involves avoiding hazards, such as driving carefully, taking precautions in terms of hazards of fire, a suitable exercise program, etc. The abstaining behaviors may include not smoking, not overeating, not selecting fattening foods, so that one does not add to those hazards that might be present. These two go together creating an environment of self-protection. The critical ingredient in common is that the individual uses his own personal interest, know-how, ingenuity and resources to achieve the risk reduction.

The second approach not only looks at the micro system, but also looks past the individual to the macro systems. This approach is risk reduction by means of group or community

activity -- hazards are alleviated or eradicated. Activities that would lead to the removal of lead-based paint, so that young children in ghetto apartments would not be exposed to lead poisoning, dealing with those who continue to sell unfresh meats that may have botulism; dealing with car dealers who sell Black and poor people defective automobiles; working on slum landlords; and filling of hazardous waste sites are all examples.

There is still another dimension in this whole business of wellness that is beyond the mere absence of diseases and the deterioration of health -- the intellectual and spiritual well-being. In order to address some of these issues, both the micro and the macro, including the intellectual and spiritual issues, we at California State University at Fresno, just this past March, after six to eight months of study and planning, working with the County Health Department, the County Social Services Department, and a community group sponsored out of one of the local Lutheran churches, established a Center for Health Promotion in the Black community of Fresno. The Center is called the West Fresno Center for Nursing and Health Promotion. In planning for the Center, we needed to deal with a working definition for health promotion.

There are two definitions prevalent in the literature. One defines health promotion as providing information, opportunity and a supported environment in which individuals may change lifestyles to reflect positive health behavior. The other defines health promotion as any combination of health education and related organizational, political, or economic interventions designed to facilitate behaviors and environmental adaptations that will include or protect health. Let me draw your attention to the fact that in the second definition, we go far beyond changing lifestyles of individuals. We chose the second definition because in the Black community the issues of community organization, of poverty, of political clout, and economic interventions are absolutely necessary if one is to deal with the individual as a whole. We borrowed from the University of Wisconsin, Stevens Point, Wellness Committee, a concept of wellness. They defined wellness as an active process through which individuals become aware of and make choices toward a more successful existence.

In the Black community, or in any community, the health promotion program must recognize not only the importance of health concepts, but also the significant role played by the individual's self-concept and the culture and the environment

of that community. It must include such dimensions as social, intellectual, occupational and spiritual well-being. In order to address these issues and to achieve a goal of health promotion encompassing a broader focus on the individual, one must involve the active participation of churches and ministers, educational systems, parents and teachers, principals, civic groups and community leaders, the traditional community health organizations, and the traditional social service organizations. All of these must work together in a joint enterprise in order to have all the forces in the community focused on health promotion. The Center is planning a coordinated approach through the schools, the employee peer groups and social clubs; but instead of focusing, as most of the health promotion endeavors do, on the individual, the Center decided that its major focus would be on the family unit. The Center, however, began its initial thrust with the traditional wellness program activities that dealt with obesity, smoking, lack of exercise, improved diet, stress, and the question of consumer goods.

The Center's objective is to focus on the causes of disease development, the perception of self-worth and how that perception can influence health and wellness. Much of what we know about the causes of suicide and homicide in the Black community stem from a distorted sense of self and self-worth. This clearly is a very large task for the Center, and in trying to address it, there is no pat answer. The staff is just beginning to work at how one deals with this issue, in a concerted way, on a large community-wide basis.

The first task of the Center's staff is to make some assessment of the health status of the community. They have chosen the Lifestyle Assessment Questionnaire (LAQ) from the University of Wisconsin, Stevens Point, as the basic instrument for this assessment. The LAQ will help in creating a profile of the needs and wishes of the community related to health promotion and disease prevention. It will be administered at the Center on a regular basis and through churches and civic organizations. A computer printout will be provided to each individual on the results of the questionnaire with follow-up interpretive group sessions. The individual results will assist the staff in identifying the micro issues to be addressed in the program. The cumulative data will be used to identify the macro issues to be addressed. In this way, both micro and macro components of wellness will be encompassed.

The results (of the LAQ) will be used as an educational tool to enhance the understanding of the community about its health risk status. The task of organization of the community to

alleviate or eradicate the health hazards will employ the principles and techniques of social work community organizations. So often health professionals fail to use a multidisciplinary approach in dealing with the issues of health promotion and wellness.

The center plans to utilize the resources of the School of Health and Social Work by involving faculty and students from the array of departments: Communicative Disorders, Health Sciences, Nursing, Physical Education, Physical Therapy, Recreation, Rehabilitation Counseling, and Social Work. From other schools in the University, the Center will provide skills in management and marketing, urban and regional planning, food science and nutrition.

In order for the program to have a mass base, the staff is developing a comprehensive list of community leaders and not just the normal leadership of ministers, teachers and other professionals, but also beauticians, barbers, and natural indigenous leaders within smaller groups.

The center will begin with the traditional wellness program activities: groups on stress management, exercise, blood pressure screening, parenting - with emphasis on conflict resolution and child abuse, physical assessment, and lifestyle analysis. The staff will develop a health newsletter, a slide presentation, and a program bulletin. Marketing students and faculty will provide material for the local Black newspaper, radio and television with public service announcements. Weekly Words on Health for church bulletins, posters, and fliers for local businesses, are part of the marketing concept. Community health students and faculty are planning a clean-up campaign and community beautification program. They are starting to identify slum landlords and take legal action against recalcitrant owners. The Center is attempting, in its program of health promotion and wellness, to go far beyond the traditional exercise programs established in White middle class communities.

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PARTNERSHIPS IN HEALTH PROMOTION FOR BLACK AMERICANS FROM A CONSUMER PERSPECTIVE

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I may have told Dr. Scott that I retired in 1979, and I became a full-time housewife. Soon after my retirement, my husband was diagnosed as insulin restricted diabetic. So in the last six years, I have studied the aging process as well as studied the survival for insulin dependent diabetics. I am, at this time, at my house in Chesapeake, taking a postgraduate course in those areas: insulin dependent survival for my 70 year old husband and surviving the process of aging.

This is a beautiful arrangement here for me because I looked at the calendar as a two layered cake, because they have the heavy's on each side, masculine Ph.D.'s; and in the middle you have the filling, an aged housewife and mother.

Partnerships are characteristics of us as Black people. We are a group of such distinction in a general sense, that there is no problem in distinguishing us from other groups. Since one drop of Black blood makes us wholely Black, we have easily found our "visual places." I read a statement on a girl scout calendar some time ago. The statement related that there is no other group that pulls together like Black people. Historically, as we migrated from the south to the north and started "making it there," then other relatives were sent for and we supported them as they tried to "make it" until they could provide for themselves. In our struggle to make it in America as first-class citizens, the National Association for the Advancement of Colored People was founded. The Crisis Magazine, the official organ of the N.A.A.C.P. tells us of our history, our past and our present struggles to be first-class citizens in America.

Our Virginia Education Association Journal today replaces the Virginia Teachers Association Journal following the 1954 Supreme Court decision and the merger of the VEA and the VTA. The VTA Journal gave us the Black perspective of our educational problems, solutions and achievements. Today we also have our National Black Press, and locally we have our own Black newspaper, The Norfolk Journal and Guide, which struggles to give the Black perspective of our news.

Health has been and still is for us as Black Americans, a major problem. There was a time when we could not (here in the local area) get a job as a cook nor as a maid until we obtained a health card. The health card indicated that the

holder was free of venereal disease. This was before domestic workers were required to have the Social Security card. This health card assured the employer that the worker would not pass venereal disease on to the employer's family. The late Dr. D.W. Byrd tells us his nephew was found to have a positive Wasserman test. In his concern to help his nephew and all people, especially Black people with the V.D. problem, Dr. Byrd started the first venereal disease clinic in Norfolk City. Blacks had previously organized for religion, for education, for politics, etc. Now with the partnerships of the United States Public Health Service, and the Old Dominion Medical Society, an association of Black doctor's here, Dr. Byrd brought needed help throughout the area to hundreds of Blacks affected with syphillis and other venereal diseases. Dr. Byrd's clinic was later merged with the Health Department of the City of Norfolk.

Like Dr. Byrd's nephew, persons who were found positive for syphilis or gonorrhea were put on file and had to report to the clinic or to their private physicians regularly for a prescribed program of treatment. If one failed to go for the regular treatment, that person was apprehended and incarcerated at the then Norfolk City Farm where the treatment was continued. Today, the employer, the health department, the medical societies and associations and other health organizations are aware that most diseases are not affected by race, creed or color. Now better health for everyone is everybody's business. We are bombarded for better health by the news media, radio, television, various health agencies and facilities, health practices and products.

We need the concerted effort of making our people aware that a pill is not needed for every pain or every symptom; that our health is purchased more at the food counter than at the drug counter; that we are not the owners of backaches, headaches, saying "my back aches, my arthritis, my headache." Physically and mentally, we as consumers must focus on our individual health. Each must study and know himself or herself. Then we must also focus on the fact that we are our brother's keeper. The strong must bear the infirmities of the weak. Those who have must help those who have not, as we Blacks mostly have always done. We who know must help those who do not know.

On the other hand, health is an individual entity. God in his divine plan has so wonderfully made us that each single one of us is endowed with the potential of our own health, and I say again individually. On a March of Dimes poster is this statement, "The baby growing inside its mother is in a most dependent and risky place." In the first trimester, as early as two and one half weeks, according to Avery's Developmental Embryology, the zygote has developed to 1.5 mm in length with the primitive streak, gut, neural groove, and the primitive

vascular system. These developing systems are already at work before the end of the first month of pregnancy. In this fetal state, this little consumer's primodal system receives whatever the consumer mother's system provides. Biologically, this new life began with the genes of the father fusing with the genes of the mother, whatever the quality of the genes. In other words, the quality of the genes may affect the quality of the health of this minute consumer at conception. Alteration or mutation may occur in the genes. Gene changes in embryonic development may be biological, physiological or chemical. They may be caused by radiation, viral infection or by other possible causes. The mother as a consumer truly needs to realize that the life of the tiny consumer developing within her body is solely dependent upon her for its physical and mental health. The mother's body is chemical; the developing fetus is also chemical. The basic 7's which the mother is advised to eat daily are composed of the same substances as the egg which her body produced for the new life, as is the sperm produced by the father for the new life. (Organic Chemistry Morrison and Boyd) Protein, carbohydrates, fats, minerals and water are found in all living cells and these tissues. Protein makes up the largest part of the body. DNA is a primary protein of the genes; this is a chemical.

The consumer needs to know that in His divine plan of life, God has provided us with laws and principles, principles of checks and balances, limits and interdependencies. We find these laws at work in the biological conception, the chemical makeup and in the physiological processes of life. The consumer needs to reflect on the fact that it is necessary for life, the beating of the heart is interdependent with the breathing. If the activity is increased, then the rate of the heart beat is increased. The increase in activity demands an increase in the respiration. If the air is polluted, there is a greater increase in the respiration in order to obtain the necessary oxygen for the oxidation of the food, and to provide the energy for the original activity. Yes, God has wonderfully made us, with laws and principles of interdependencies, checks, balances and limits as a means of naturally maintaining our health which we received from our parents.

Partnerships and more partnerships are needed to produce a better, more intelligent consumer. One of the greatest needs for Black Americans is in this area of education. We as Black consumers need scientific education. Had the pregnant mother chosen even general biology and general chemistry, she would have known something about metric measurements, the symbolic language of science and mathematics. This kind of knowledge is necessary so that we can understand what we read in the news media or hear on the radio or see on the television. We have too many of our Black Americans who do not stay in school

long enough to take either biology or chemistry courses. There are too many of our children who drop into the school, but not to learn anything from the books. My oldest son graduated from Crestwood High School in 1960; he majored in football and band. He had a long school day to include all of those practices. Academics were certainly his minor subjects until his father joined me in motivating him to strive for some degree of excellence. He was able to attain an average, such that he was able to use that football scholarship that he was offered for college. Even at the senior year in college, he did not get that degree in music and right now I cannot even hope that he will get the degree. He is now on a world tour as a professional musician. He says that he does not need the degree.

As a teacher of a 10th grade biology class, I tried to reach every student to some degree. I was shocked when I tried to read a scribbled test paper. So I called the student for a conference. Guess what my 10th grade biology student said to me about his own test paper? He said, "You read it, I can't read." Most of the time, this child's parent would not be found attending PTA meetings. So for him and for them, we need practicing partnerships for the families, the PTA or the civic groups in trying to urge the student not only to remain in school, but to learn something while he is there.

As consumers, we need to be aware of the availability, products, facilities, agencies and personnel for the promotion of health. As consumers in partnerships, we can better be aware of some of these resources. Remember, we are chemicals; there is a limit to be maintained. Wellness means that there is a chemical balance maintained. Our body seeks to maintain its own balance naturally. This knowledge is available at the 10th and 11th grade high school level. My urgency and concern is that we have partnerships working together in order to help the parent to teach and to encourage the student to remain in school and at the same time learn something while he or she is there.

We were on a mission with the Social Awareness Committee of our church last week, and it was pointed out how much there is in our Black communities that a lot of us may not know. We went into a particular home where the mother had four beautiful, healthy children; they were fat anyway. When we asked the mother the shoe size for the 20 month old baby and the 12 year old, she did not know; what dress size did the little eight year old girl need, she did not know. The children readily came up with some answers. Somehow or another in this little home, there needs to be some kind of input from those who know. Partnerships have worked for us as Black Americans. Togetherness can make a difference for all Americans.

PARTNERSHIPS IN HEALTH PROMOTION FOR BLACK AMERICANS FROM A RELIGIOUS PERSPECTIVE

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Traditionally, the Black Church has had a very supportive role in this partnership for health promotion for Black Americans. What has happened down through the years, however, is that the church has abdicated that role. There was a time that if a member of the community became ill, the church knew about that illness and in various ways tried to help to alleviate not only the illness but also the conditions that may have led to the illness.

With the advent of some of the social programs, the church is now in a position of almost complete abdication. Not only does the church not go to the aid of members of the community who are down, out and/or ill, but we find ourselves in the position of sometimes not knowing and, sadly, not even seeming to care. The church has a definite role in a meaningful partnership with Black Americans in terms of health and welfare.

There is, first of all, a need in the Black Church for awareness. If the Black Church is to regain any modicum of concern for the health and welfare of its members, there must be evident a higher level of awareness on the part of that church. This level of awareness stems from biblical principles. We are told in the bible that indeed, we are our brother's keeper. That which affects someone across town or across the world, in like fashion, affects us as well. We cannot have malnutrition, as has been mentioned here earlier, we cannot have tainted foods, neglect, unemployment, sickness and the like existing in the community and the church not responding in a loving, caring and effective manner.

As essential as it is, simply attending, church on Sunday is not the most effective witness. True witnessing, it appears to me, should be evidenced through committed, meaningful service. Although we may have worshipped, we have not really performed explicit service to mankind except through prayer. Not only this, but not to witness opens us to the charge of "abdication of our responsibilities."

I think that it is instructive for the Black Church to understand that Jesus Christ, our example, used this world as his example. In his great Sermon on the Mount he spoke of the things of this world with which one has to be concerned. If we take care of things in this world, then the next world will take care of itself. If, on the other hand, we have not taken care of the things of this world, I am confident we shall experience some sort of difficulty on the other side. Now I thoroughly believe that we are admonished, as a church, not to "cross over to the other side of the street" when we see others in trouble. I believe that health and welfare are definite ingredients in assuring that we "not cross over" to escape our duty. The social ministry is actually the real ministry of the church. It is through this type of ministry that we are able to show that we love Jesus by showing Christian love towards our brother and sister.

Now, you ask, what are we doing at Greater Mount Zion Baptist Church to help us live out our commitment to the Gospel of Jesus Christ? To begin with, we have a social awareness committee. The social awareness committee grew out of the necessity to have someone with a loving, knowledgeable, and caring spirit to lead in helping people help themselves. Sister Thelma Clemons has more than aptly filled this role. Her charge was to look at some of the problems in the community to see how we as a church might begin to address those problems. Out of our over-all concern, then, grew our projection for starting and/or expanding the health and nursing aspects of the church program. For example, uniforms of the nurses will, in our church, stand for things related to health and not only the usual Sunday morning activities. What we are attempting to do at Greater Mount Zion is to become instructive in our health/welfare commitment. This past Saturday, for example, we had a very good turnout for blood pressure screening and education. We are also embarked on a program to teach members of the congregation how to take blood pressure readings so that we can offer that as an ongoing service for members of our congregation at least one day a week. Many of the members of our congregation should have their blood pressure checked regularly. Initially, at the least, we intend to make this service available on Sunday mornings.

The question of weight control, diet and proper eating habits is another area in which we plan to establish programs. In a previous church, we were able to get a man who had been on a heavy salt intake for a long time, who swore up and down he would never change, to reduce to almost zero his daily intake of salt. This man had been using salt a great deal of his life and proclaimed he would probably die eating it. Well, we

told him, that's exactly what was going to happen to him, "he would die eating salt." But, as stated, he cut his salt intake. He said later, rather sheepishly, that he was wearing clothes for the first time that he had not worn for several years. This pleased him and encouraged us. While this was only one case, we feel that the process is replicable.

There is another thing that we accomplished in my previous church with a student doctor visiting the home of someone who had a chronic health condition. This medical student went to the home to "monitor" the lifestyle of this individual with the chronic condition to see if he could suggest things, on an ongoing daily basis, to be of some service not only to the sick person, but the family as well. The medical student, usually intending to specialize in family medicine, would instruct other members of the household in some of the things that they may do to help to ease the pain and/or make life more comfortable for all concerned.

Along with this, we have utilized the concept of looking at the kinds of drugs that our church members were taking. This again was in our former setting. We have not initiated this at Greater Mount Zion. We had the congregation bring in their drugs in a "brown bag." They individually sat with a qualified pharmacist while the pharmacist examined the drugs. He might say to the member, for example, "your headaches may be coming from the combination of drug A and drug B." "These two drugs," he might continue, "normally are not prescribed together." Or he may say that, "250 mg of this, along with 25 mg of this is not a good combination." In some cases, a member may be taking medicines prescribed by one doctor, while being attended by another. In such cases, the attending physician might not be aware of this situation. The pharmacist would then suggest that the members go back to their attending physicians and ask them to check out their latest findings. As simple as these things appear, they may have far reaching consequences. It certainly shows, if nothing else, that the church does care.

Another thing at which we are looking is the problem of the handicapped. What can we do as a church to help some of the handicapped to some greater self-awareness? We are finding that there are a number of things, beside simply bringing them to church on Sundays or special days, that we might do. We are looking into this in an ever widening but realistic circle.

Time will not allow me to go into all of the things we are either doing or planning to do. However, just let me leave with you a five prong attack that I think might be workable in the church situation.

1. Churches must become Pro active rather than

Reactive.

We know that we eat a lot of pork. We eat a lot of chitterlings, a lot of pig feet and a lot of salt. We know this, and I don't know about suddenly taking these out of the diet. If you suddenly take away all of my pig feet, chitterlings, and greens cooked with fat meat, you sort of bother me. I am sure I would feel like saying "what's happening?" Our people, Black Americans, eat a lot of these kinds of things.

It is one thing to eat these things and not be aware of their consequences; it is another to be aware of the consequences and yet persist in following the same practice. As a church, we become pro active and say, "wait a minute, when you eat those pig feet, collards cooked with good ole fat meat, and all those sweet potatoes and yams, you must be aware of what is happening to you." We would, now and then, suggest an alternative. Maybe instead of having pig feet on Monday, chitterlings on Tuesday, pig tails on Wednesday, fat back and cabbage on Thursday, etc., instead of having it every night, maybe cut down and have them only one night per week. Do you understand what I'm saying. Not necessarily cut it out, "cold turkey," but cut down. Eventually, there may be complete withdrawal. That's pro active as I see it. So one attack would be to become pro active through education and gentle persuasion. Let us not wait and then react, but see the merits of being pro active in the several aspects of the life of the members of the church.

2. Seek the Servant Function of the Church

When you come to church on Sunday morning, you are coming to worship God through Jesus Christ. We are there to give thanks for all His goodness, His mercy and His grace--for what He has done, still doing, and will do. The servant functions begin after the worship, doesn't it? After the bell rings and everybody says amen, then the service begins. So I suggest that we reclaim the servant functions of the church. That is to find out what little things as a church, we might do to "...help lift the burden of others..." and let's do them in the spirit of Jesus Christ.

3. Ask "How" and "Why Not" rather than simply "Why"

How can we do this better? Why not a program on such and such? How can we get them interested? How can we explain this program? How can we make this program self-sufficient? Why shouldn't we do this? Why shouldn't we do that? These kinds of questions will prompt the servant functions of the church. God, through Jesus Christ has given us so much. We have the obligation to look around us and ask the proper questions in order to see Him lifted up as we work through Him to accomplish great things.

4. Form a Consortium of Churches

One of the things we are working towards is to form a consortium of churches. This consortium would be composed of churches whose leaders have a great and specific interest in the health and welfare of their members. If we can get church leaders to come together and bring their churches together, and talk about health and welfare of the Black Community--then we have made a proper start. As few as 10 churches, which may represent as many as 5,000 to 10,000 members--or less--will affect the lives of 50,000 Black folks, or more, in matters of diet and everything else. It will spread like a mushroom. After the devotional service the consortium, with a pre-planned agenda, could move into the business of the day--people. The Bible teaches, "I was sick and you should have done something...I was feeling depressed and you should have done something," and so forth. I am suggesting that a consortium is a novel way to really impact a large number of people.

5. Develop Goals and Objectives

We should say where as a church we are going and not just "wonder and wander" down the road. Remember, the central role of the church is witnessing. Now, you ask, how do you make Goals and Objectives practical in a church? First, pray for guidance. Then, include Godly principles and outcomes in each and every goal and objective. Be specific for God as God wills and grant it so. Then, involve each auxilliary of the church and each willing member, in establishing these goals and objectives. Then, go again to your knees to seek out Jesus Christ's aid in touching the hearts of all to help your church meet these goals and

objectives. Your goals and objectives should be broad enough to include the range of human needs. At Greater Mount Zion Baptist Church, our goals are broad enough to include meals on wheels, mass adoption of families to see their needs throughout the year, such as clothing, health, transportation, education, etc. The Holy Bible is our guide. The goals cause us to be ever mindful of our specific responsibilities to our brothers and sisters.

Yes, the church does have a role. It is vital and demanding. We must not abdicate this responsibility. We are to go back to our churches and communities with a determination to lead our churches, under God and His undershepherd, into the vital position "doing."

Brother Ford spoke of wellness. This implies the total person. What are we as a church doing about it? Churches can make a difference. If we move to love totally, we will see a change.

PARTNERSHIPS IN HEALTH PROMOTION FOR BLACK AMERICANS FROM A BUSINESS PERSPECTIVE

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As health care costs began escalating at rates far in excess of inflation the business community became interested in identifying alternatives for controlling or limiting health care cost. This concern for controlling costs comes at a time when Blacks are increasing their use of health resources. The increase experienced by Blacks is due partially to health benefits programs of employers. To tamper with benefit programs just as Blacks begin to gain racial equity in the use of health resources could prove to be damaging to a business if not handled carefully. The increase of health care resources is illustrated by the rate of new paid visits by Blacks of all ages to physicians in their offices was 60 per 1000 in 1980 and 1981. The corresponding White rate of 6.7 per 1000 in 1980 was not significantly higher than the Black rate (Knapp 1984 p.6).

In order to reach Black consumers many chief executive officers are forming partnerships with Black leaders and community organizations that provide health information and services to Blacks for the purpose of educating the health consumer and at the same time not tarnish the reputation of the company. Many chief executive officers feel that educating employees and the general public on ways to contain medical cost would be effective.

Results of a survey involving the 25 leading corporations in the State of Virginia revealed the following information or feeling:

- Health care cost to be a significant financial or personnel problem for their company.
- Interest in passing on medical cost to employees as a preventive measure.
- Feeling that competition in the free enterprise system would reduce cost.
- Utilization of outpatient services, second opinions for surgery, elimination of unnecessary weekend hospitalization, encouraging employees to go to cheaper hospitals and the use of preventive medicine all as a means to reduce cost.

The business community understands better than anyone else the benefits of establishing partnerships to promote health care. A partnership can help business to reach a market with their product that may otherwise not be reached, it is a way of educating the consumer about good health care and as a result reducing cost to businesses. It is also helping consumers to use preventive medicine as a way of reducing cost to businesses.

A local community group can strategically introduce business to the constituency it has established by co-sponsoring or endorsing their programs. The Budweiser Community Health Mobile is an example.

These newly formed partnerships between business and the community have served in mobilizing community leaders to recognize the critical problems of escalating health care costs. During the past few years, the health community has seen an influx of alternative delivery systems, prospective payment programs, the redesign of benefits to make consumers/providers sensitive to price, and benefit programs to stimulate the use of cost efficient delivery mechanisms.

Purchasers of health care insurance have a wide variety of cost containing plans from which to choose, including HMO's, PPO's comprehensive plans, and "custom-tailored" plans with strong utilization review components.

The prevalent attitude of "top quality health care, necessary or not, at any cost," appears to have shifted to "necessary services at reasonable costs".

Finally, the role of private philanthropy in financing health care in the United States has always been important. The new emphasis on the minority community stems from the fact that research has made us all more aware of Black related illnesses such as sickle cell anemia and hypertension.

Private philantropy is a tradition deeply ingrained in America encouraged on the frontier and legally encouraged in the Internal Revenue Act by granting tax incentives.

PARTNERSHIPS IN HEALTH PROMOTION FOR BLACK AMERICANS FROM AN EDUCATIONAL PERSPECTIVE

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One of the things that is really important in terms of promoting health care for Black Americans is the continued development of minority providers. That is what educators are responsible for doing in this process, training new and old practitioners. What I want to talk about today is the growing need for minority leadership in health care. There are too many allied health practitioners that have received their entry level Allied Health Education and have taken a back seat in the church waiting for some sort of emancipation. They have become lost in the crowd and will in no way be able to impact on policies which will affect the quality of health care for disadvantaged Americans. Therefore, if we are to cure many of the diseases that plague disadvantaged Americans, we must have practitioners who are willing to prepare themselves beyond the entry level. Allied Health Practitioners who seek continued discipline, specific training, advanced degrees and community service opportunities are more likely to receive leadership type appointments with majority and/or minority institutions, the big pay off being active participation in institutional policy making.

I am sure that all of you will agree that there is little or no minority participation in the decision making process at majority health care facilities. The void not only exists in health care facilities but throughout public service institutions. This very point was expressed in an article of recent issue of Ebony Magazine. The article featured the results of a poll of minority students enrolled in majority universities. When asked, "what is the most prevailing need at majority universities?" the minority students responded by saying more Black faculty and administrators. Those students are crying out much the same cry as do our patients in majority health care facilities, "we have no one to call on for help"; that is, no one who really cares about or understands the problems which are unique to Black Americans. In my home state (Mississippi), there is no relationship between the number of minority patients and the number of minority Allied Health Administrators. Not only are there no Blacks currently holding the many Allied Health administrative

positions, there are not any who are qualified to fill any of the positions. When I look at my colleagues in other states I find that this problem is not unique to Mississippi. As long as we do not have leaders, we do not have a stake in the policy making process. An Ebony survey of over 1200 Black Americans reported unemployment and education as the most prevailing problems facing Black Americans today. It is very important that we link employment and education together, because without the appropriate education, gainful employment is usually not possible. Therefore, it is imperative that we educate our students to meet the standards set by our discipline specific professional associations. Further, our students should be educated holistically in an environment similar to that which they will become employed in. Each student should graduate with the attitude that, "I am going to be the very best health care provider this institution has ever employed." This attitude is the beginning of the making of a leader. Over the past few years, I have developed more than ten potential allied health leaders by using the following basic principles.

1. Academic Preparation

   High quality academic programs are a requirement if our students are going to be competitive. Academic preparation usually determines whether the students develop to the pre-determined competency level. It also influences the student's clinical performance and/or performance on licensing examinations. The clinical portion of the program should always include several different types of affiliations. Most importantly the student should be scheduled for rotations in health care settings similar to the majority of the related job opportunities. This is necessary for adjustment prior to employment. It is important that the minority health care practitioner be given every opportunity to adjust prior to employment so that he does not start his first job behind the pack. If he starts behind, it takes forever to catch up with his White counterparts, and he may never pass them. However, given the right academic preparation and a chance to begin at the same point or ahead of the competition gives the new graduate a better chance of becoming a leader. Not only is it advantageous for the graduate to have diverse clinical affiliation exposure, it is also in the best interest of minority patients. Please stop and think about where the majority of the minority patients are receiving hospital care. I do not know about your states, but in Mississippi they are being treated in majority institutions because there are no

minority health care facilities. Therefore, I am suggesting that the students be excellently prepared in the classroom and laboratory settings and placed into majority clinical affiliates with minimal faculty sheltering. Academic excellence is the primary link in the chain of activities which develops leaders.

2. Attitudinal Adjustment

A potential leader must have a good attitude. The following is a list of statements associated with a poor attitude: "It is a job, good pay, easy work, I passed, etc." If this attitude does not change during the educational process, the student is doomed to become a bench practitioner, not a leader. The poor attitude statements should be changed to reflect the following good attitude statements: "Professional employment is my short term goal; to become a department head is one of my long term goals; and my earning capacity will equal the services that I render to my patients and community." There should be sessions where the students are counselled individually about setting goals. They should be taught the difference between short and long term goals. They should be taught to set realistic goals as not to become frustrated if they do not become supervisors after two weeks of entry level employment. In summary, the practitioner with a good attitude knows that his earning capacity and advancement capabilities both depend on the quality and quantity of services rendered and his continued professional development.

3. Assertive Training

Written and oral communication skills are essential if a practitioner is to become a leader. Early diagnosis and treatment of poor communication skills must be done by the Allied Health Educator. If correctly taught, communication skills can be learned in a one to two year period. The most creative mind in the world is useless if no one knows it but the owner. Ideas and thoughts must be shared with peers and superiors or otherwise nobody knows there is the capacity to think and be creative. The student must learn to orally express himself if for no other reason than self-defense. The student should be advised on how to present himself when faced with certain situations, not carried through by the faculty. Role playing is the

only time that faculty intervention should take place. The role playing sessions should be video taped and individually discussed with the student. After several sessions, improvements should be noted in the following areas: tone and voice pitch; body language; mannerisms; eye contact; and posture.

4. Adaptive Skills

The American Society is made up of one main culture and several smaller subcultures. The main culture is made up primarily of White Anglo Saxon Protestants. Hispanics, Jews, Blacks, to name a few, represent some of the smaller subcultures. The main culture outnumbers all of the individual subcultures and controls most of the wealth and power in this country. Understanding that the main culture is in control, members of the subculture groups should think about ways in which some of the power and wealth could be shared. The first step to overcoming the barriers that exist between the main and subcultures is to identify the characteristics of the cultures in question. After common characteristics have been identified, the adaptation process must take place. It is not rational to think that the main culture will make wholesale changes in order to make a subculture group more successful. The main culture does not have to change because it is in control anyway. However, there are certain adaptations that a subculture group can make if its members want to share the wealth and power of the main culture. The main culture as a whole is considered to be polite, intelligent, professional, well groomed, good mannered assertive etc. The Black subculture would be much less threatening to the main culture if its members would assume more of the characteristics of the main culture. I am not advocating changing the students entire lifestyle or value system; I am only suggesting that while interfacing with members of the main culture one should give the very best impression possible. Wearing a hat and sunglasses during indoor class is an example of poor adaptation. This is a behavior that should be corrected by individualized counseling. To me it is simple, if one wants to enjoy the wealth and power of the main culture, then one must adapt even if only during business hours, to the accepted characteristics of the main culture.

5. Active Involvement

We must get our students involved in a variety of professional and community activities. In my opinion, involvement breeds success. Student involvement in school activities, community services, political movements and local and national professional associations gives the student and the profession external exposure that would not ordinarily be available. The exposure to problems and concerns beyond the normal work day should create a kind of curiosity in the student which leads to more involvement and subsequent solutions to many problems.

If nurtured properly, the same curiosity will be carried from the student phase to the practitioner phase. The bottom line is that active people stand above the crowd because they are in a minority. It has been stated that 80% of the work done in this country is done by only 20% of the people. I promise you that active involvement pays off. In closing, I am sure by now you have noticed that all five developmental areas began with the alphabet "A". Individuals who strive for continued improvement in the above mentioned five areas are eternal members of the "A" team. The "A" team is a winning team. As educators we must develop our students in all five areas if we are to have leadership that genuinely cares about the health care of minority patients.

PERSPECTIVES ON THE HEALTH STATUS OF BLACK AMERICANS FROM A PROFESSIONAL PERSPECTIVE

AN INNOVATIVE RESIDENCY PROGRAM IN TRANSCULTURAL PSYCHIATRY: ST. THOMAS, VIRGIN ISLANDS

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Washington, D.C.

There is an increasing challenge to expand psychiatric training in diverse cultural settings. The Department of Psychiatry at Howard University Hospital in Washington, D.C. has accepted that challenge by instituting an innovative rotation in transcultural psychiatry based in St. Thomas, United States Virgin Islands.

In the April 1984 issue of the Journal of Hospital and Community Psychiatry Drs. Collins, Mathura, and Risher in their article "Training Psychiatric Staff to Treat A Multicultural Patient Population," realized both cultural and linguistic barriers have affected the intricate therapeutic alliance between patient and therapist, particularly when coming from different cultural, ethnic, and racial backgrounds. The Department of Psychiatry embarked upon this challenge by incorporating culturally relevant material in their curriculum by including a program of seminars and didactic sessions to familiarize the staff and trainees with cultural patterns of the varied ethnic groups of foreign students attending Howard University. To further realize this goal plans were made to include actual training in the field in a unique cultural setting.

The first rotation in transcultural psychiatry takes place in the United States, Virgin Islands. The rich culture of the West Indies proved to be an overwhelming learning experience. It has also afforded the trainee an opportunity to serve in a physician shortage area as well as a chance to impact upon the health status of a segment of the Caribbean population.

More than 100 islands comprise the United States Virgin Islands which are located 1500 miles S.E. of New York, 1200 miles S.E. of Miami, 70 miles S.E. of San Juan St. Croix lies to the south of St. Thomas, with St. John and the British Virgin Islands to the N.E. and are situated in the Atlantic standard time zone. These U.S. territories are part of the curving Antilles chain which separates the Caribbean and Atlantic--and are among the most beautiful geographical areas of the world.

The islands lie directly in the path of the soft gentle tradewinds blowing from Portugal. They were discovered by Columbus. However, 1500 years later Denmark had claimed St. Thomas, the French--St. Croix, and the British-Tortola. Later Denmark began a thriving sugar cane industry. Slaves were imported to work the large sugar plantations. The Virgin Islands were also used as a seaport and gateway for the shipment of slaves to other parts of an expanding world. After the Danish abolition of slavery in 1848, planters began to abandon their estates and the local economy and resident population declined. On March 31, 1917, St. Thomas, St. Croix, and St. John were bought by the U.S. for $300.00 an acre. In 1927 the residents were granted U.S. citizenship.

St. Thomas is 32 square miles long or 13 miles long and 3 miles wide. The capital is Charlotte Amalie, named for an early queen of Denmark. St. Croix is 28 miles long and 7 miles wide. Two-thirds of the island of St. John, a 20 minute ferry ride from St. Thomas, is a national park donated to the U.S. government by Lawrence Rockefeller in 1956.

Since the inception of the program, the Department of Psychiatry at Howard University Hospital has sent individual residents for three to six month tours of duties in the Virgin Islands. The residents stay at a motel owned by the Virgin Island government for use by medical personnel, better known as the "Motel Michille". Transportation consists of cycling, walking, bus, open air taxis and government transportation between hospitals. They utilize the British driving convention--driving on the left, which can make driving a real adventure.

The new St. Thomas Hospital has a 250 bed capacity with an emergency room open 24 hours a day. It also has an acute psychiatric ward run by Dr. Leighman Lu. During my rotation I interviewed patients and performed neurology and consultation liaison psychiatry with Dr. Lu. Not far from the hospital was located the office of Ms. Patricia Todman head of the Division of Mental Health, Alcohol & Drug Dependency Programs, U.S. Virgin Islands. Weekly inservice conferences and team meetings were held there.

The transitional clinic was a clinic for those patients recently discharged from the acute care unit who needed the assistance of a structured day care program. The patients participated in a sewing group, worked as food vendors and tended their own vegetable garden. At the transitional clinic I saw follow up patients and prescribed their medications.

A few feet away in another building known as the "Old Hospital" or the Knud Hanson Memorial Hospital a long term

care unit is located on the second floor, town clinic and the step down unit on the first flor. In the long term care facility the resident physician tends to both the psychological and physical needs of the patients. While on rotation there I reinstituted a progress flow sheet to improve patient information documentation and to assess patient progress. The Town Clinic is an outpatient clinic where individuals and families would be seen and court ordered psychiatric evaluations would be performed. A clinical psychologist is also based there to do the psychological testing.

The Step Down Unit is a facility for people who had been chronically ill, but are now stable enough to function on a semi-independent basis. During their stay they would actively seek employment and acquire skills by working in the "Gifted Hands" workshop. In addition to these clinics they also have an Alcohol and Drug Dependency unit located therein. On the far end of the island was the rural East End Clinic which also provided a day care center. Individuals and families would also be seen there. A child psychiatrist would come in once a month and he would also take the ferry to St. John to see patients. The "Pathway House" was located in the city for a few clients who could live and work under minimal supervision.

Other activities included participating in mental health month with the St. Thomas Mental Health Association and Health Awareness Fair. Meetings and seminars were also held with the U.S. Marshals to familiarize them with techniques to be used in psychiatric emergencies.

St. Thomas is rich with beauty and culture. This proved to be a significant factor in relating to the patients because with such a deeply rooted culture, it took time to establish trust and rapport with the patients and staff. It was not uncommon to work with patients who believed in Obeah, a type of voodoo or witchcraft. The Rastifarians, a religious group, believed that everything should be natural. They also smoked 'ganga' or marijuana as a part of their religious rites which often resulted in a form of a toxic psychosis. My experience revealed that you had to take their belief system into consideration and incorporate it into their treatment plan in order to gain compliance.

I feel the rotation in the Virgin Islands is a beneficial one for the resident physician and the patient. As part of future plans, the Department of Psychiatry has plans to expand the program to include longer rotations, possibly increase the number of residents that may participate, and include a possible fellowship. The Howard University Hospital program has proven to be a progressive step forward in the advancement of transcultural psychiatry. It is further evidence of the

continuing commitment to enhance the quality of life and improve the health care status of people of color everywhere.

B I B L I O G R A P H Y

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RESEARCH AND POLITICAL PERSPECTIVES

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INTRODUCTION

The subject of professional regulation has received a significant amount of attention recently. Studies of physicians, lawyers, and other professional workers are increasingly focusing on the social costs of regulating professionals. This paper looks at the impact professional regulation has on minority employment in allied health. The very nature of professional regulation is to be restrictive. The greater the restrictiveness, ceteris paribus, the greater the benefits to those who are within the regulatory boundaries, and the more likely otherwise qualified workers will be excluded. The exclusion of workers because of the licensing requirements does not in itself have to be discriminatory. However, if the testing instrument or the requirements to qualify for the test can be shown to be discriminatory, then the licensing in effect becomes discriminatory.

The next section of the paper discusses the economic theory of professional licensing. In this section I will present two competing theories of professional regulation; the consumer protection theory and the professional monopoly theory. The third section will discuss professional licensing in physical therapy and occupational therapy. In this section data on the number of states currently licensing these professions is presented along with the numbers of Black PTs and OTs. A test of the impact of professional regulation on minority employment is presented and discussed. The final section discusses the results and the policy implications of the study for physical therapists, occupational therapists, and other allied health occupations.

THE ECONOMIC THEORY OF PROFESSIONAL REGULATION

There are two competing theories of professional regulation: the consumer protection theory, and the professional monopoly theory. Each theory has its supporters, and each theory can point to examples of behavior which support the theory, and each theory is logically consistent. Thus, it is difficult to determine which of the two is relevant for the conditions in a particular market. In this section I will outline the two theories and discuss what both theories have to say on

minority employment.

Consumer Protection Theory Of Professional Regulation

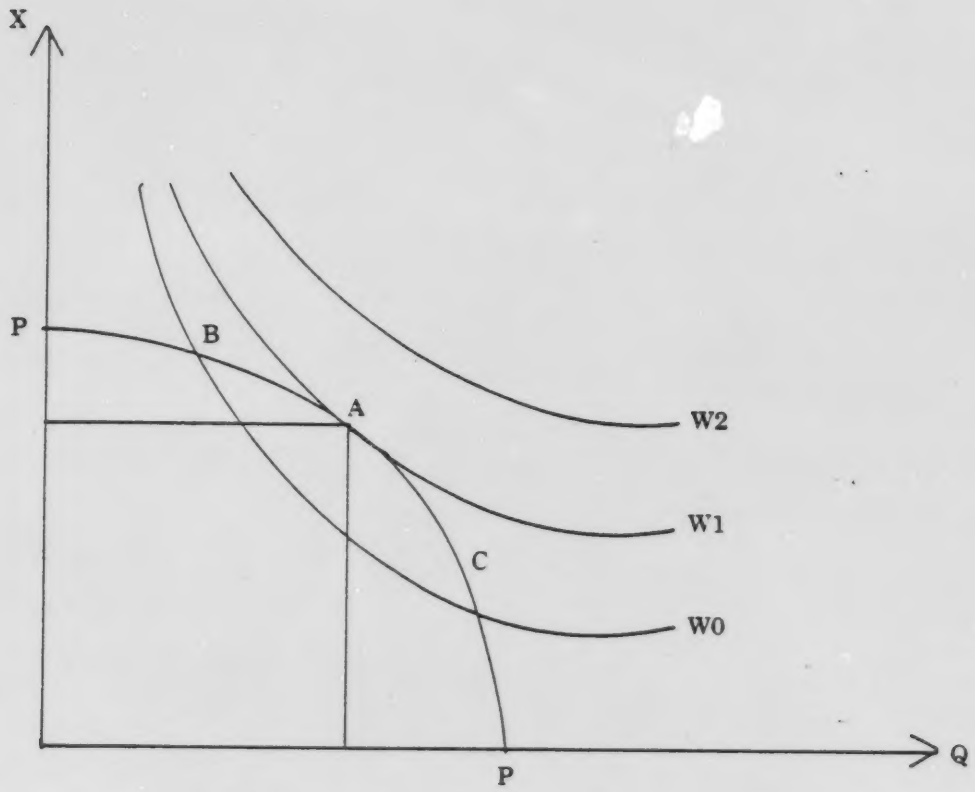
The rationale for professional regulation, or for that matter regulation of any kind, is in the motivation. In the late 1890s, Jacob Riis wrote passionately on the housing conditions in New York's tenements.(1) As a result of the exposure of these decrepit conditions, laws were put in place to regulate the number of persons or households that can live in one dwelling. In a similar fashion, regulations to improve the quality of physicians were implemented after Abraham Flexner toured the country for the Carnegie Foundation to study the conditions of the nation's medical schools.(2) What he found was an "unacceptable" variation in the quality of medical schools. As a direct result of these findings, and in the interest of improving the quality of physician services, a number of medical schools were closed. This particular regulatory action had a devastating effect on the number of Black medical schools. As a direct result of this report, five Black medical schools were closed.(3)

The theory that consumers need protection from unscrupulous producers of some goods or services is based on an assumption of consumer ignorance. Consumers, it is argued, just do not have the information to determine whether a good or service is "right" for them. Whether that good is housing, physician services, or automobiles the rationale is the same. Economists have noted that it is incorrect to assume that all consumers are ignorant, or that all consumers want the type of protection that regulation of this type provides.(4) Furthermore, it is argued that it is not necessary to have every consumer in the market reasonably informed. As long as there are a significant group of informed consumers, the remainder of the population, like sheep, can follow them, and thereby make the right decisions.

The problem with this sort of "let the market decide who gets what quality of goods or service" is that the consumption of some goods can be so hazardous that there is no chance for consumers to learn from their mistakes. Thus, the consumer protection theory argues that the government or the producers themselves must sufficiently regulate the production of that good or service, even at the cost of restricting the freedom of certain classes of consumers and producers.

The consumer protection model is illustrated graphically in Figure 1. In Figure 1 the curve labeled PP shows the trade-off between quantity (Q) and quality (X). The assumption of a trade-off between quantity and quality is a recognition that schools of allied health can produce a large

Figure 1



number of low quality professionals, or can produce a smaller number of higher quality workers. The decision of what combination of quantity and quality of personnel to train and employ can be determined with the use of a social welfare function (W).

Every point on a given social welfare function represents a common level of social well being. Increases in social welfare are illustrated by outward shifts in the social welfare function. Thus, W2 represents a higher level of utility than W1, and W1 is superior to W0. In the consumer protection model, social welfare is primarily a function of having a quality of services such that consumers have a small risk of being harmed by the professional.

Under these conditions, if the goal is to maximize society's welfare, this will be accomplished when the society can reach the highest level of welfare given the quantity-quality trade-off. On Figure 1 this point of maximum social welfare is given by point A. At point A a combination of quality and quantity has been chosen which takes into consideration the desire of consumers to be protected and to have adequate supplies of allied health professionals.

Changes in society's desire for high quality can be easily accommodated by moving the social welfare function closer to the quality axis. Thus, if there were a greater demand for quality this could be shown by rotating the social welfare function so that it is tangent to a point like B. Similarly, a desire for more quantity can be shown by rotations in the social welfare function so that the tangency occurs at a point like C. As is clear from the above discussion, the location of the social welfare function is the determining factor in that combination of quantity and quality of allied health workers are trained. Which groups in society make these decisions in the consumer's interest is therefore important. If the professionals in conjunction with governments make these decisions then it is possible that the combination chosen reflects the desires of consumers. However, there is a potential for these decisions to be made in a way that the interest of the professionals are more important than the interest of consumers. This is the argument made by the professional monopoly model.

The Professional Monopoly Model

Beginning in the late 1960s, economists and others began to notice some disturbing results of regulations initially intended to protect consumers.(5) They noticed that it was expensive to regulate professionals and firms. They noticed it was inflationary to regulate. And they noticed that the regulations were in many instances arbitrarily restrictive.

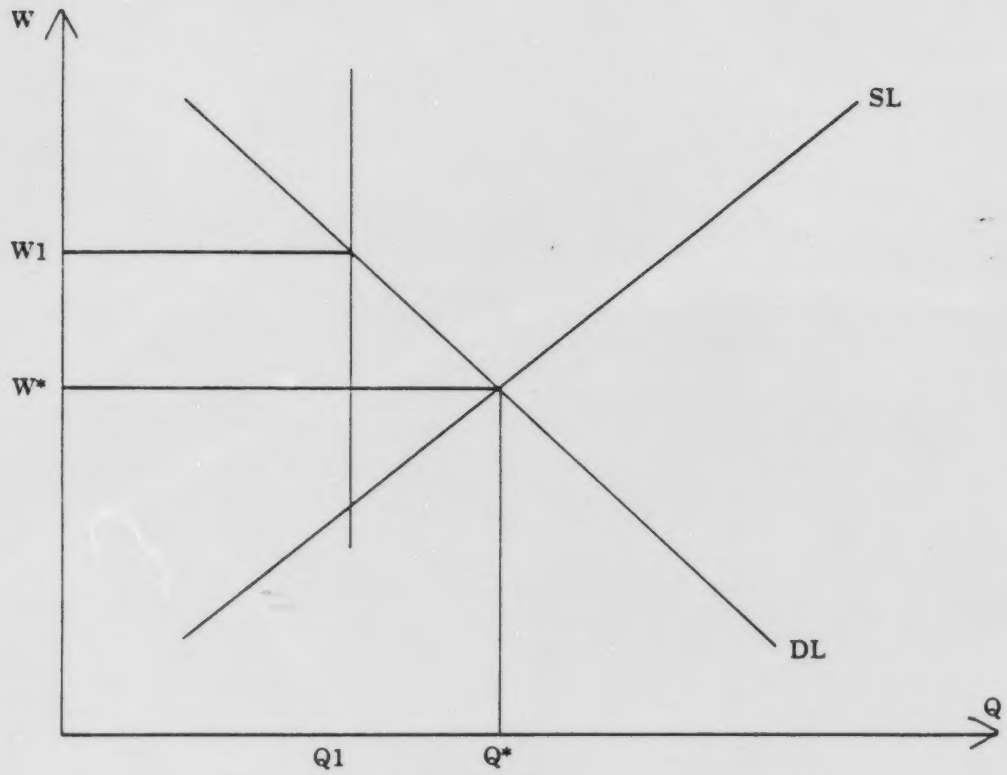
These features of the market immediately bring to mind the conditions of monopoly. It did not take long for economists to begin speaking of deregulating in the interests of the consumer. This time, however, it was not to protect the consumer from the consumption of some hazardous good, it was to protect the consumer from monopoly exploitation and higher prices.

The professional monopoly model developed currency in the mid 1970s as it became clear the physicians, lawyers, morticians, and other professional workers had benefited significantly as a direct result of the professional monopoly granted by the regulations.(6) The rates of return to medical education were significantly higher than the rates of return in other fields that required similar lengths of schooling and training, but had fewer restrictive regulations.(7) The best explanation for these continuing discrepancies is the restrictive nature of the medical profession. In effect, the professional regulations had granted those within the profession monopoly power.

The higher than normal rates of return, the higher prices, and the higher incomes of those within the profession are sufficient reasons alone to justify a reconsideration of the societal value of professional regulation. This reconsideration is best illustrated by the federal government's attempt to impose a moratorium on professional regulation in a number of health occupations.(8) In addition to the above mentioned cost of professional regulation, there is the issue of access to services produced by the profession and participation in the profession by previously excluded groups. If the regulations are restrictive to the point of creating a shortage of services, consumers with low incomes may be effectively prevented from consuming the services. Again the case of physicians comes to mind. While the total number of physicians and physician/population ratio has increased dramatically over the past 15 years there are still rural and inner city areas that have gone unaffected by this increased supply.(9) It can be argued that less restrictive regulations will result in a greater amount of services to low income consumers. The greater supply from lower barriers can spill over into previously underserved areas. A related problem with restrictive professional regulations is the reality that when many of the regulations were first imposed, minorities were effectively excluded from the educational institutions where the skills were being taught.(10) As a result, the number of minority professionals was dramatically reduced.

The professional monopoly model of regulation is illustrated in Figure 2. In Figure 2 the demand and supply of AHPs is shown. The equilibrium wage (W*) and equilibrium quantity

Figure 2



(Q*) of AHPs is determined by the intersection of the demand and supply curves. In this equilibrium, all AHPs that want to work can find work at that equilibrium wage. Another way of looking at this equilibrium is that all employers who want to hire AHPs can hire them at the equilibrium wage.

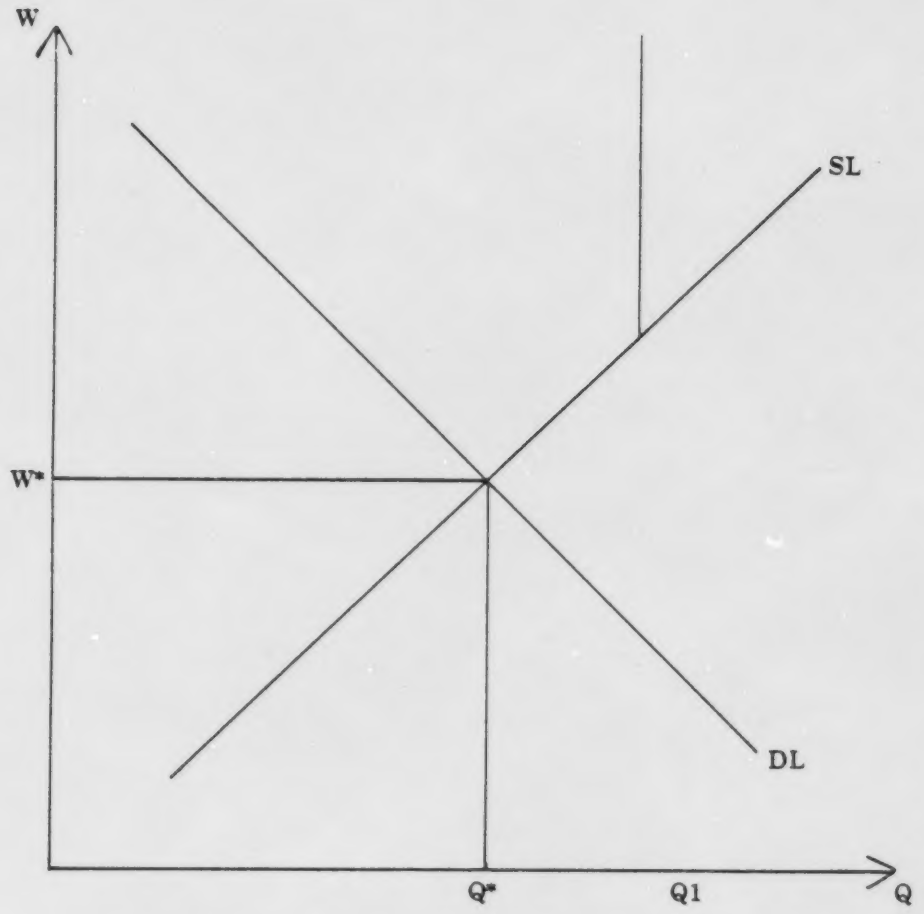
If a market restriction is imposed on the market, for whatever reasons, the effect will initially be on the labor supply curve. In Figure 2 the effect of a professional license that lowers supply below the equilibrium supply can be shown by restricting the supply to Q1. If the supply is restricted to Q1, the old equilibrium wage will no longer clear the market. At the old wage, W*, the demand for AHPs will exceed the supply, creating a shortage. This shortage will be eliminated by increases in the wages of AHPs. The new equilibrium wage with the license will increase to W1. The higher wage creates higher incomes for incumbent professionals at the expense of lower supplies of professionals and lower quantities of services produced.

The professional monopoly model argues that this ability to justify wage and income increases on the basis of quality increases creates the potential for conflicts between the profession that establishes the regulations, and the consumers who end up paying for the regulations. However, it is not necessarily the case that the regulations established are binding or restrictive. If the quality-quantity trade off decided on by the social welfare function chooses a quantity that is equal to or greater than the quantity determined by the market, the regulations are superfluous. In this situation the equilibrium in the labor market will determine the wages, incomes, and prices of services produced in the market. (See Figure 3.) Only if the regulations restrict the supply below the equilibrium, can the regulations effect wages, prices, and incomes.

Professional Regulation and Minorities

The theoretical impact of licensing and other forms of professional regulation on minority employment is ambiguous. Only if it is argued that minority workers have a different distribution of abilities can it be argued that professional regulations have a differential impact on minority employment. Take the case of a licensing exam as a case in point. Assume the licensing exam is valid and unbiased, and say correctly disqualifies the lower one third of the distribution. If more than one third of minorities taking the licensing exam fail, the exam can be said to have a differential impact. Disproportionate failures by minority AHPs of licensing exams is evidence of either a biased test, or a different distribution of skills. But the theory discussed above does not make any definitive statement on whether there is such

Figure 3



differential impacts on particular groups of workers. In order to look at the differential impact of professional regulation on minorities we have to look elsewhere.

One reason a differential impact could occur would be discrimination in educational opportunity. If minorities are excluded from the educational process which prepares them for the licensing exam, the process will have a differential impact. The other place to look for causes of racial differences in licensing is in the licensing requirements. If the test is biased or if the test is graded in a biased manner, the results will be discriminatory. One licensing requirement that on the surface does not appear to be discriminatory, but may prove to be, is some sort of licensing fee. If the distribution of incomes for Whites is significantly different than the distribution of income for Blacks, a licensing fee could be more restrictive on Blacks seeking licensing than on Whites.

While there are reasons to suspect that professional licensing and other regulations have been a greater entry barrier to minority professionals, the actual proof of such differential impact is an empirical issue. The next section looks at the effect licensing and other factors have had on minority employment in occupational therapy and physical therapy.

LICENSING AND BLACK EMPLOYMENT IN ALLIED HEALTH

A Measure of Equal Representation

When looking for explanation of racial differences in occupational choice, it is important to begin by discussing the yardstick used to contrast what is with what "should" be. This is not as easy as it sounds. The measure used in this paper to describe whether Blacks are proportionately represented in physical therapy (PTs) and occupational therapy (OTs) is the ratio of Black PTs (OTs) per 100,000 Blacks divided by the total number of PTs (OTs) per 100,000 in the population. If for example, Blacks and Whites were identical in all respects except race, and for every 100,000 persons 16 were PTs, then one measure of an equal distribution for Blacks would require sixteen Black PTs for every 100,000 Blacks. Under these circumstances the ratio measuring the degree of equality would be equal to one. If the number of PTs (OTs) in the population per 100,000 exceeded the number of Black PTs (OTs) per 100,000 Blacks the ratio would be less than one. A ratio less than one is not prima facie evidence of racial discrimination, but it does indicate imbalance. Moreover, the closer the ratio is to zero, the greater the racial imbalance. The reason why this measure is imperfect is in the implicit assumption that White workers and Black workers share similar occupational preferences. Is it safe to assume that proportionally, Blacks and Whites desire to work in the same

occupations? Sowell and others answer, no.(11) If the preferences for the thousands of occupations in the economy differ significantly by race, any attempt to judge discrimination based on relative proportions in a given occupation is beginning with erroneous assumptions.

I concede that the measure used here is vulnerable to that criticism, but I initially just want to describe. If in that description there appears to be glaring differences in the respective distributions in an occupation by race, i.e., ratios significantly greater than one, it is appropriate to ask why?

Data

The data is from the 1980 census, the American Occupational Therapy Association, the American Physical Therapy Association, and the Council of State Governments. The state census data provides information on the number of Black PTs, OTs and Blacks in the state. In addition total numbers of PTs, OTs, and the state populations are taken from the 1980 census. The licensing information was provided by the Council of State Governments. In addition to these sources the American Occupational Therapy Association and the American Physical Therapy Association provided data from their membership survey on income, employment and license pass rates.

Data Analysis

Table 1 shows the distribution of total PTs per 100,000, total Black PTs per 100,000 Blacks and the ratio of the two for each state and Washington, D.C. in 1980. The ratio of Black PTs per 100,000 Blacks ranged from zero in 14 states to 200 per 100,000 in Idaho. The ratio of total PTs per 100,000 ranged from 2.2 in Hawaii to 37.6 in New Hampshire. The absolute number of Black PTs ranged from zero in 17 states to 367 in New York. The ratio of Black PTs to total PTs ranges from zero in the twelve states with no Black PTs to 100 in Idaho.

Table 2 shows the same information for Occupational Therapists. The ratio of Black OTs per 100,000 ranged from zero in 26 states to 15.7 per 100,000 Blacks in Nevada. The totals for the population ranged from zero in Alaska to 23.3 per 100,000 in New Hampshire. The Black to total ratio ranged from zero in 26 states with no Black OTs to 2.74 in West Virginia.

Before attributing the small numbers of Black PTs and Black OTs to restrictive licensing, it is helpful to first look at the characteristics of states with low relative proportions of Blacks. One characteristic of the 17 states without Black PTs and the 26 states without Black OTs is the small number of

TABLE 1:
Total Physical Therapists per 100,000, Total Black Physical Therapists per 100,000 Blacks and the Ratio of Black per 100,000 Blacks to Total per 100,000

State	Total per 100,000	Black per 100,000	Ratio
Alabama	5.01	6.5	1.28
Alaska	5.47	0	0
Arizona	11.99	0	0
Arkansas	7.61	0	0
California	17.70	12.9	.72
Colorado	14.26	15.7	1.41
Connecticut	28.64	12.4	.43
Delaware	14.64	14.6	1.00
D.C.	13.63	11.6	.87
Florida	11.80	13.3	1.12
Georgia	5.56	10.2	1.81
Hawaii	2.28	0	0
Idaho	2.33	200.0	100.0
Illinois	11.96	8.5	.71
Indiana	9.49	5.8	.61
Iowa	13.42	0	0
Kansas	13.79	0	0
Kentucky	6.53	5.0	.76
Louisiana	4.64	5.6	1.20
Maine	28.99	0	0
Maryland	21.11	8.2	.39
Massachusetts	29.89	16.7	.56
Michigan	8.67	4.8	.55
Minnesota	25.56	41.5	1.61
Mississippi	7.74	3.3	.42
Missouri	14.56	10.1	.69
Montana	19.32	0	0
Nebraska	13.82	0	0

Table 1 (continued)

State	Total per 100,000	Black per 100,000	Ratio
Nevada	13.82	0	0
New Hampshire	37.69	0	0
New Jersey	13.85	7.67	.55
New Mexico	16.64	0	0
New York	15.20	15.3	1.01
North Carolina	12.92	7.1	.55
North Dakota	23.29	0	0
Ohio	11.06	16.9	1.54
Oklahoma	12.20	3.9	.32
Oregon	17.32	43.2	2.50
Pennsylvania	15.37	11.9	.78
Rhode Island	16.05	67.8	4.12
South Carolina	6.95	8.0	1.15
South Dakota	9.41	14.4	0
Tennessee	5.21	18.5	2.78
Texas	14.03	0	1.32
Utah	13.35	0	0
Vermont	25.42	10.7	0
Virgina	8.92	0	1.20
Washington	21.01	11.4	0
West Virginia	13.34	0	.85
Wisconsin	27.66		0
Wyoming			

Source: U.S. Census 1980.

TABLE 2:
Total Occupational Therapists per 100,000, Black Occupational Therapists per 100,000 Blacks, and the Ratio of Black per 100,000 to Total per 100,000

State	Total per 100,000	Black per 100,000	Ratio
Alabama	2.21	0.9	.406
Alaska	0	0	0
Arizona	7.14	0	0
Arkansas	9.62	2.7	.280
California	7.27	1.9	.261
Colorado	9.69	0	0
Connecticut	5.53	0	0
Delaware	7.23	0	0
D.C.	11.12	12.9	1.16
Florida	3.09	2.9	.930
Georgia	3.94	1.1	.279
Hawaii	2.28	0	0
Idaho	2.38	0	0
Illinios	6.40	1.8	.281
Indiana	5.48	0	0
Iowa	4.43	0	0
Kansas	8.21	0	0
Kentucky	3.52	5.4	1.53
Louisiana	3.07	3.1	1.01
Maine	9.60	0	0
Maryland	4.78	2.7	.560
Massachusetts	15.76	13.5	.854
Michigan	7.89	4.6	.584
Minnesota	10.55	0	0
Mississippi	.87	0	0
Missouri	7.00	4.7	.671
Montana	10.93	0	0
Nebraska	5.48	8.3	1.53

Table 2 (continued)

State	Total per 100,000	Black per 100,000	Ratio
Nevada	6.62	15.7	2.38
New Hampshire	23.35	0	0
New Jersey	6.42	6.5	1.01
New Mexico	1.23	0	0
New York	8.82	5.2	.588
North Carolina	3.66	1.3	.354
North Dakota	6.59	0	0
Ohio	6.18	3.1	.502
Oklahoma	2.15	0	0
Oregon	4.10	0	0
Pennsylvania	8.34	0.2	.023
Rhode Island	5.70	0	0
South Carolina	1.99	0.7	.352
South Dakota	9.41	0	0
Tennessee	1.42	0.7	.493
Texas	5.29	4.9	.925
Utah	2.94	0	0
Vermont	8.41	0	0
Virgina	6.04	2.7	.466
Washington	9.90	0	0
West Virginia	1.13	3.1	2.77
Wisconsin	12.34	0	0
Wyoming	1.83	0	0

Source: U.S. Census 1980.

Blacks in the state. For PTs the state with largest Black population and zero Black PTs was Arkansas with 374,000 Blacks. The average Black population for the 17 states without Black PTs was only 51,000. In the remaining 34 states reporting some Black PTs, the average Black population in the state was 918,000. Similarly, the average number of Blacks in the 26 states without Black OTs was 102,000. By comparison, the number of Blacks in the 25 states with OTs averages 2,657,000. These statistics show clearly that the number of Black professionals like other professionals produce services that can be extremely personal. Because of racism and personal preferences to be treated by someone like you, Black professionals have largely been restricted to producing services for other Blacks. This pattern is true for lawyers and physicians.(12) These market conditions make it unattractive for Black PTs or Black OTs to practice in states with low Black (and minority) populations.

Further evidence of the effect the size of the Black populations has on the numbers of Black PTs and Black OTs can be illustrated by ranking the 10 states with the largest Black populations. Table 3 shows the ratio of Black PTs (and OTs) to total PTs (and OTs) in the states with the 10 largest Black populations. In these states the mean ratio for PTs was 1.05, and for OTs the ratio was .547. The PT ratio of 1.05 indicates that Black PTs are distributed in the population in these states with the same frequency as all PTs. In six of these 10 states the Black PTs per 100,000 Blacks actually exceeded the total PT per 100,000. The mean ratio for all states for PTs was .497. The total OT per 100,000 in these states was almost twice the Black OTs per 100,000. The mean ratio for OTs in all states was .395. A conclusion from these numbers is that Blacks are more proportionately represented in states where there are large numbers of Blacks.

Another factor that needs to be controlled before looking at the effects licensing has on Black employment of OTs and PTs is the number of Black OTs and Black PTs being trained. Unfortunately, state data on the number of Black OTs and PTs in educational programs is sketchy. However, Bisconti (1982) 4 percent of OT masters students nationwide.(13) Data from the APTA and AOTA indicate that over the past 10 years there has been only a moderate increase in the percentages of Black PTs and Black OTs. In 1973, 1.4 percent of AOTA members were Black. By 1982 that had increased to only 2.0 percent.(14) In 1978 1.4 percent of APTA member were Black and by 1982 the percentage of Blacks decreased to 1.2 percent.(15) These numbers indicate that Blacks coming through the educational system are not coming out in large enough numbers or fast enough to significantly increase the proportion of Black PTs

TABLE 3:

Ratio of Black per 100,000 Blacks to Total per 100,000 in the Ten States with the Largest Black Populations

States	Physical Therapy Ratio	Occupational Therapy Ratio
New York	1.01	.35
California	.73	.26
Texas	1.32	.93
Illinois	.71	.28
Georgia	1.82	.28
Florida	1.12	.93
North Carolina	.55	.35
Louisiana	1.20	1.01
Michigan	.55	.58
Ohio	1.54	.50
Average in Above States	1.05	.547

and OTs.

The attempts here to isolate the effects of licensing are limited by the paucity of published data on total and minority pass rates. What is known on these two occupations is the following:

1. Licensing is required in all 50 states and Washington, D.C. for Physical Therapy;

2. Licensing is required in 26 states for Occupational Therapy (fifteen in 1980);

3. The total nationwide pass rate on licensing exams was estimated to be 88 percent in Occupational Therapy by the AOTA; and

4. The total nationwide pass rate on licensing exams was estimated to be 88 percent in Physical Therapy.

One way to use this limited data is to first compare the proportions of Black professionals per 100,000 in the states that require licensing in OT with the states that did not require licensing in OT. Table 4 looks at the Black to total ratio in the 15 states that required licensing in 1980. The mean ratio was .844 in the 10 states requiring licensing with positive numbers of Black OTs and .783 in the states not requiring licensing and with a positive number of Black OTs. A simple comparison of means indicate that there is no statistical difference between states with licensing and those states not requiring licensing. Licensing does not appear to have restricted the ability of Blacks to enter occupational therapy.

Similar comparisons cannot be made for PTs since all states require licensing. But given the identical pass rates, and the similar lengths of training for OTs and PTs one would expect similar distributions of Blacks in both occupations. In fact Blacks are better represented in the occupation with stricter licensing.

CONCLUSIONS AND POLICY RECOMMENDATIONS

Professional licensing in occupational therapy and physical therapy has not directly reduced the numbers of Black professionals in these occupations. Black professionals are limited primarily at the education stage. Small proportions of Blacks (minorities) in masters programs in Physical Therapy and Occupational Therapy is the primary reason for the small numbers nationwide. Moreover, states with large numbers of Blacks are more likely to have large numbers of Black OTs and Black PTs. While data on where minority PTs and minority OTs

TABLE 4:
Ratio of Black per 100,000 Blacks to Total per 100,000 in Occupational Therapy in Those States Requiring a License to Practice

States Requiring Licensing (1980)	Ratio
Arkansas	0.28
Connecticut	0
D.C.	1.16
Florida	0.93
Georgia	0.28
Iowa	0
Louisiana	1.01
Maryland	0.56
New Hampshire	0
New York	0.59
Ohio	0.50
Oregon	
South Carolina	0.35
Utah	0
West Virginia	2.78

Source: U.S. Census

are trained is sketchy, traditionally Black colleges and universities have been a major source of Black PTs and Black OTs. Howard University in Washington, D.C., Southern University in Louisiana, and Fisk University in Tennessee have trained large numbers of Black PTs and OTs. It is not coincidental that these three states have representative proportions of Black PTs and OTs.

Public policy to increase the numbers of Black PTs and Black OTs should focus primarily on increasing the numbers of Blacks in PT and OT programs. Continued support of traditional Black colleges, increases in educational information to minority high schools students, and better dissemination of job opportunities in physical therapy and occupational therapy are policy options that have not been fully exploited.

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12. Black physicians have a clientele that is 80% Black. At the same time however, 80% of Black patients have White primary care physicians.

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14. AOTA Active Member profile 1982.

15. APTA membership survey 1982.

added facilities. The final legislation indicated that publicly funded hospitals would be available to everyone and a certain percentage of free care would be provided to the poor. It took a series of lawsuits in the early 1970's to resuscitate these two long-ignored provisions of the Act (the community service and uncompensated service obligations). These provisions will be discussed later. In its Declaration of Purpose, the original Act stated:

> The purpose of this title is to assist the several states - (a)... to develop programs for construction of such public and other nonprofit hospitals as well, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospitals, clinics, and similar services to all their people; and (b) to construct public and other nonprofit hospitals in accordance with such programs.(7)

From its inception in 1946 until 1975 when the Hill-Burton Act was replaced with the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), it has been estimated that the Hill-Burton Program was responsible for $15.2 billion in hospital construction; $4.2 billion in direct construction subsidies and $11.0 billion in nonsubsidized construction.(8) With about 60 percent of the grants going to private nospitals, the Hill-Burton Programs have become a huge subsidy of the hospital industry. More than 110 million in grants were awarded in fiscal year 1974 alone; matched by nearly 384 million in other state and local funds. These grants went to 245 facilities. As of 1974, federal aid had accounted for approximately nearly one half million inpatient care beds and about 3500 outpatient care facilities. In total over 6500 public and voluntary hospitals nationwide had received funding under the program. More specifically, as of July, 1974, the Hill-Burton Act involved almost 11,500 projects for nearly 6500 facilities in approximately 4,000 communities. By 1983 there were approximately 7,000 Hill-Burton facilities.

The Uncompensated Care and Community Service Obligations

The legislation imposed uncompensated care and community service obligations on state plans and hospital grant recipients. It required the nondiscriminatory delivery of:

> Adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color, and for adequate hospital facilities for persons unable to pay therefore. Such regulation may require that before approval of any application for a hospital or addition to a hospital is recommended by a State agency assurance shall be received by the State from the applicant that (1) such hospital or

addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each group; and (2) there will be made available in each hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay therefore, but an exception shall be made if such a requirement is not feasible from a financial standpoint.(9)

These obligations represented Congressional intent at the time to assure adequate health care to poor and rural persons without regard to race, creed, or color. Note the allowance for the State Plan to provide "separate but equal" services. This seemed to be reflective of the Congress view of what constituted nondiscrimination at the time. As will be discussed, the "separate but equal" provisions were to remain intact for nearly twenty years until the passage of the Civil Rights Act of 1964. The earlier federal regulations issued to implement the law reflected the "separate but equal" provisions. Today, these obligations are particularly beneficial to people not covered by neither private medical insurance nor by publicly financed programs such as Medicare or Medicaid. Thus, in times of high unemployment and large cutbacks in federal programs the potential benefit from these Hill-Burton obligations would be quite substantial. Those who tend to benefit more from these obligations are the medically indigent. One recent report estimates that 25 million people have lost health insurance because of unemployment. But many of these people possess too many assets to qualify for Medicaid.(10) Because, Congress did not include provisions for the implementation and enforcement of the uncompensated care and community service obligations, health facilities conducted "business-as usual" and ignored these obligations for 25 years.(11) As a result, the obligations later became the basis for a number of challenges to hospital admission policies.(12)

The Uncompensated Care Obligation

The uncompensated care or "free service" obligation guarantees a reasonable annual volume of free care to the indigent and/or those unable to pay for 20 years from the opening of the facility built with Hill-Burton funds. In its first enforcement effort of the free service obligation, DHHS then DHEW in September, 1971, issued and circulated a draft regulation within DHEW and to the American Hospital Association and the American Medical Association. This draft

proposed that a facility would be in compliance if it budgeted for free services which equaled or exceeded "5 percent of its estimated patient revenues".(13) Eight months later in April, 1972 when the draft became a formal proposal the "presumptive compliance" level was changed to 5 percent of the costs of operations as opposed to estimated costs of patient revenues (less that attributable to Medicare and Medicaid) or 25 percent of net profit.(14) However, promulgation of the regulation produced drastic changes which reduced the level of service constituting "presumptive compliance" to either 3 percent of cost of operations (less that attributable to Medicare and Medicaid) or 10 percent of the Hill-Burton grants received by the facility, which was less.(15) In addition the maximum time for the operation was limited to 20 years from the opening of the facility or portion thereof receiving the grant. This limitation was added at the approval of the Federal Hospital Council who had been granted the power to approve regulations under the original Hill-Burton Act until 1974 when its authority was removed with the passage of National Health Planning and Resources Development Act of 1974.(16) However, beginning with the year 1985, the 20 year rule excludes virtually all facilities opened with Hill-Burton funds since 1965. It is estimated that between 200-300 facilities meet the 20 year rule each year.(17)

Under a second option in the 1972 regulations known as the "open door" option, hospitals could not exclude prospective patients who needed services but were unable to pay; and they had to provide services free or at reduced cost to these needy patients once admitted. Although this option did not specify a minimum or maximum dollar amount, many hospitals sought not to comply with the option. They admitted individuals who were unable to pay but did not publicize their additional obligation to provide free or reduced cost medical care. In fact many hospitals had no mechanism for determining who is unable to pay and therefore eligible to receive Hill-Burton uncompensated services. Needy patients, like those unable to pay, were subject to collection actions. Hill-Burton hospitals were also required to post notices stating the availability of Hill-Burton Services in appropriate areas, such as admissions offices and the emergency room.

Current regulations issued effective September 1, 1979 eliminated the open door option. Hospitals must either meet the 10 percent or three percent rules described above in exchange for having accepted Hill-Burton funds. Hospitals are required to maintain records of the costs of uncompensated services for public review.(18) In addition if hospitals do not provide the required amount of free services over the specified period of time, it cannot use the 20 year obligation as an explanation for not providing the remainder of its free care. If a hospital fails to provide the required amount of

uncompensated services, it is required to make up the deficit by providing additional services in future years, over the 20 year period. Conversely, a hospital can credit an overage of free care to shorten the 20 year period.(19)

The 1979 regulations also required that Hill-Burton hospitals not only post notices but provide written notice to all individuals who are seeking their services. The individual written notice must state several items including the fact the facility is required to provide a reasonable amount of services without or below charge to people who cannot afford to pay for care and set forth the criteria the facility uses for determining eligibility for uncompensated services; and the facility will advise a person in writing within two working days whether the person is eligible for uncompensated services. Figures 1 and 2 are examples of public notices hospitals must display on uncompensated care, until their obligation in this area has been met. These posted notices are provided by DHHS as required by the 1979 regulations. In addition facilities must publish plans annually for allocating uncompensated services and must keep accounting records which clearly separate uncompensated services from other services and expenses. If for any reason (except financial inability) a Hill-Burton aided facility does not provide its required level of uncompensated care, an affirmative action plan must be developed to help the facility meet its annual compliance level. The facility must report each year if it does not provide the full level of uncompensated services.

The more than 4600 facilities which now have an uncompensated obligation are expected to provide more than $500 million in free care. To receive Hill-Burton free care recipients must meet certain financial criteria (poverty guidelines). These criteria are devised by DHHS. The 1984 financial criteria are provided in Table 1. These guidelines must be used by Hill-Burton facilities to determine eligibility for free or below cost care.

The Community Service Obligation

Under the Community Service Obligation a Hill-Burton facility must guarantee access to anyone who lives or works in the facility's geographic area. This obligation exists for the life of the facility.(20) Under the current 1979 regulations as part of their community service obligation, Hill-Burton financed facilities may not deny emergency services to persons living or working in the area such needed treatment because he or she cannot pay for it; nor can they require a cash deposit before admitting a patient. They must admit Medicaid and Medicare recipients. Facilities having Hill-Burton community service obligations must also display a posted notice in highly visible areas (See Figure 3).

Figure 1

HOSPITAL NOTICE

HILL-BURTON PROGRAM
(Uncompensated Care Obligations)

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

This health care facility is required to give a reasonable amount of its services free or at a reduced charge to persons who cannot afford to pay for medical care.

If you are not able to pay for all or part of the care you need, please contact the Admissions or Business Office of this facility and ask about the availability of such care.

If you feel you have been improperly denied free or reduced-charge care, call Toll Free 1-800-638-0742 (Maryland residents call 1-800-492-0359) for assistance.

Figure 2

HOSPITAL NOTICE

HILL-BURTON PROGRAM
(Community Service Obligations)

This health care facility has met its obligation to provide a reasonable amount of its services free or at a reduced charge to persons who cannot afford to pay for medical care under the Hill-Burton Program, Title XVI, regulations 42 CFR part 124.

In accordance with our remaining community service obligations under this program, this facility will continue to make its services available to the general public and is prohibited by law from discrimination. Emergency services will not be denied to any person who resides in this facility's service area on the ground that the person is unable to pay for these services.

If you are eligible for assistance under Federal or state programs, this facility will aid you in making the necessary arrangements. Contact the admitting office.

Figure 3

HOSPITAL NOTICE

HILL-BURTON PROGRAM
(Community Service Obligations)

THIS FACILITY IS LEGALLY OBLIGATED TO SERVE THE COMMUNITY

This health care facility is required by law to make its services available to all people in the community.

This facility is not allowed to discriminate against a patient because of race, creed, color, national origin, or because a patient is covered by a program such as Medicaid or Medicare.

If this facility provides emergency services, it must not deny those services to a person who needs them but cannot pay for them.

If you believe you have been improperly denied services, contact:

Office for Civil Rights
U.S. Department of Health and Human Services

If a facility cannot meet this obligation it must make arrangements to come into compliance in some other manner. For example, if a Hill-Burton facility has physicians with admitting privileges who do not treat Medicare/Medicaid patients the facility must hire or contract doctors that take Medicare/Medicaid patients, or a facility can require its physicians to treat a certain number of charity care patients who meet Hill-Burton eligibility requirements. According to a Pennsylvania Superior Court, a Hill-Burton hospital can suspend physician staff privileges for failure to provide charity care.(21) In the case a physician refused to meet this requirement and his staff privileges were suspended. The Court ruled that the hospital's requirement was neither arbitrary nor unreasonable and that hospital bylaws furthered a permissible governmental goal, that of providing medical care to indigents. A Hill-Burton facility's failure to comply with these obligations may result in loss of license, accreditation, and/or its Medicare/Medicaid reimbursement.

The 1972 regulations placed enforcement with the states. Only a few vigorously assumed a significant role in Hill-Burton enforcement. The 1979 regulations removed enforcement responsibility from the states and gave it to the federal government. The regulations require that DHHS must obtain reports from Hill-Burton facilities, investigate complaints, insure compliance, and obtain recompense for individuals who are wrongly denied free care.

The Courts and Hill-Burton Obligations

From 1946 to 1963 state plans and hospitals had met the community service obligation through the "separate but equal" language in the legislation. Stated another way, during the first seventeen years of the legislation federal funds were used to support a racially separate hospital system.(22) The legislation had authorized states to practice separate but equal racial discrimination and permitted segregated facilities to qualify for Hill-Burton funding. In 1963 the Fourth Circuit Court of Appeals found this language and practice unconstitutional in the case of Simkins v. Moses H. Cone Memorial Hospital.(23)

By 1963 seventy segregated hospital facilities had received Hill-Burton funding and many others, while not segregated engaged in various overt and covert discriminatory practices.(24) Sixteen years later, by 1979, about 40 percent or roughly 496,000 hospital and long term care facility beds received financial assistance through the Hill-Burton program.(25)

In Simkins a group of Black physicians and dentists along with several of their Black patients challenged the separate but

equal provision at Moses H. Cone Hospital and Wesley Long Community Hospital, both in Greensboro, North Carolina. Neither hospital had permitted privileges to Black practitioners and Cone Memorial rarely admitted Black patients. Both hospitals had received sizable Hill-Burton grants. Cone Memorial had received $462,000 in 1954 and $807,950 in 1960. Long Community had received $1,617,150 in 1954 and $66,000 and $265,000 in 1961.(26) The plaintiffs alleged that they were being denied equal protection under the Fifth and Fourteenth Amendments of the Constitution. The U.S. District Court disagreed on the grounds that private hospitals were not instrumentalities of the federal government.(27) Upon appeal, the Fourth Circuit reversed on the rationale that receipt of Hill-Burton funds by hospitals represented the "necessary" degree of federal and state involvement and participation. The separate but equal provision in the Hill-Burton legislation was declared unconstitutional.(28)

Congress amended the legislation to reflect the Court's decision with the passage of the Civil Rights Act of 1964. Title VI of the Act makes specific reference to nondiscrimination prohibitions when a program or activity receives federal financial assistance. In regards to the charity case or uncompensated service obligation in the Hill-Burton Act, DHEW (now DHHS) the agency charged with administering the Act, gave no attention or further specification in program regulations or guidelines to this obligation. The obligation was not only ignored by DHEW but also by Hill-Burton state and hospital grant recipients.(29) Beginning in 1972 and later in 1975 and 1979 DHEW, after a number of complaints, issued interpretative regulations specifying the meaning of the uncompensated service obligation.(30) After the 1979 regulations DHEW decided to emphasize immediately the uncompensated service obligation(31), while OCR assumed responsibility for the community service obligation.(32) Each of these new regulations were brought about as a result of court decisions.(33)

In the early 1980's judicial redress was still being used to challenge hospitals compliance with the uncompensated care service provision of the Hill-Burton Act. For example, in Hospital Center at Orange v. Cook, the plaintiff after explaining her financial situation could only pay $350.00 of her teenage son's $2,060 hospital bill was sued by the Hospital Center for the remaining balance. The hospital had even agreed to reduce the bill if it was paid in full in six months.(34) However, at no time did the hospital provide information to her regarding its Hill-Burton obligation. The New Jersey court held that a hospital's failure to comply with the Hill-Burton notice requirements "constitutes an absolute bar to the right of the hospital to sue" patients who should

have received services without charge or at below cost.

Despite the New Jersey court's finding, Freifield has observed that the decision must be interpreted cautiously for two reasons. First, the decision relied heavily on New Jersey case law. Thus cases in other states must be based on those states' case law. A state's case law may be similar or different. Second, the decision suggests that all administrative remedies must be exhausted before litigation can be pursued. State court actions during the administrative exhaustion process may also be based on state case law.(35) In summary this review and analysis of the charity care obligations the Hill-Burton Act of 1946 shows that the Act has evolved from a fund for the construction and modernization of hospitals nationwide to a policy that has been subjected to continuous judicial challenges and changing interpretative regulations. The concern over the implementative effects of the Hill-Burton Act has yet to run its course. Judicial challenges are now appearing that seek to reverse recent court decisions that have favored Blacks, other minorities and low income groups.

In AHA v. Harris the American Hospital Association alleged that the 1979 DHHS regulations were an impairment and redefinition of a contract which it argued was in violation of due process. The Association further alleged that the regulations were an abuse of regulatory authority by DHHS from the perspective that DHHS was not effectuating the will of Congress and that the regulations were fiscally unsound and in conflict with the Hill-Burton Act. In Harris the district court denied the Association's request for a preliminary injunction against the 1979 regulations.(36) The Seventh Circuit Court of Appeals affirmed the decision. It is ironic that the same hospital industry who demanded the enactment of the Hill-Burton Act in 1946 now seeks to block all efforts to enforce its provisions.

In 1983 in AHA v. Schweiker (37) the Seventh Circuit in a unanimous decision upheld the uncompensated care and Community Service Regulations of the Hill-Burton Program. The court noted that Congress strongly intended for these statutory assurances to be given practical reality and that the Secretary of DHHS was acting within his authority when he promulgated the 1979 regulations.(38) The Supreme Court declined to review the decision of the Seventh Circuit upholding the validity of the regulations.(39) A decision in favor of the plaintiff (AHA) would have virtually eliminated the community service and uncompensated care provisions that benefit poor people. Favorable settlements were reached in several other Hill-Burton suits in Tennessee, New York and Oregon. The Chattanooga-Hamilton County Hospital in Tennessee agreed to provide an additional $3 million of

uncompensated care to persons unable to pay.(40) Ellis Hospital in New York agreed to provide under consent decree an additional $425,000 plus an 8 percent inflation adjustment for uncompensated care.(41) Tuality Community Hospital in Oregon agreed under consent decree to cancel specified patient bills that were incurred before 1979, to hire bilingual personnel at the end of its 20 year obligation, and to provide an additional $382,000 in free or below cost care.(42) In 1984 in Wyoming Hospital Association v. Harris the Tenth Circuit Court of Appeals also upheld the validity of the Hill-Burton regulations.(43)

Despite these losses by the hospital industry Health Advocate, a publication of the National Health Law Program, points out that the battle is far from over. It notes hat AHA "continues to complain of the burdensome nature of HHS compliance monitoring requirements and their unsatisfactory impact on hospitals."(44) Further, action by DHHS may weaken the Hill-Burton regulations. In April, 1984 DHHS drafted a proposal to eliminate individual written notice, weaken deficit make-up and excuse all public facilities from complying with the uncompensated care requirements.(45)

Federal Agency Enforcement and Compliance

The Department of Health and Human Services, the federal agency charged with the enforcement function of Hill-Burton, primary enforcement tool is the compliance report, a report that all Hill-Burton facilities must submit once every three years. DHHS may determine that these reports are needed on a more frequent basis. This report implemented DHHS nonwaivable duty to collect and evaluate data from each Hill-Burton facility that will demonstrate its compliance. Yet, a Hill-Burton legal analyst has noted that DHHS has had extensive enforcement failures, problems in investigating patient complaints, problems in ascertaining the extent of compliance on a periodic basis, and problems in taking corrective actions.(46) This same analyst also noted that hundreds of administrative complaints are still pending, many for several years and many complaint investigations and compliance assessments are superficial.(47)

In terms of uncompensated care, a General Accounting Office (GAO) study found that only a little more than 5 percent of the facilities had reported by 1982.(48) This was more than seven years after Congress had imposed the nonwaivable duty on DHHS. According to the 1977 regulations each Hill-Burton facility must furnish information once every three years. Not until the 1981 fiscal year did DHHS begin to implement a three year cycle. There were about 5400 facilities with uncompensated care obligations; 657 should have reported by January 1, 1982. However, only 377 had reported by February

12, 1982.

Further the GAO report noted that in September 1979 DHHS had recorded 315 complaints concerning hospitals' failure in meeting their free obligations. In the following two years 601 additional complaints had been filed with DHHS while only 226 had been closed. Of the closed cases only 17 resulted in decisions. The other 209 cases were closed either because the complaint was withdrawn, the problem was resolved, or DHHS did not have and could not obtain the information necessary to make a decision.(49) Worse yet, DHHS accepts the reports it receives as accurate, honest data. In terms of community services, GAO found that reported data had not been used. Overall, DHHS enforcement efforts have been labeled a sorry performance.(50) Under the 1979 regulations complainants who bring charges to DHHS against a facility for noncompliance with the obligations, may ask after 45 days that their complaint receive early dismissal so they may file in court.

Advocacy Monitoring of Hill-Burton Obligations

A major notable development since 1983 has been the increasing number of Hill-Burton advocates monitoring hospital compliance. In several states there are statewide monitoring projects with some having state government participation. At the time, most of the monitoring projects were led by legal service advocates (South Carolina, North Dakota, Minnesota, Iowa and Washington). These advocates through audits have uncovered a number of wrongful dollar claims by hospitals. In South Carolina, legal service advocates found the one Hill-Burton hospital overclaimed nearly $25,000 in uncompensated care.(51) In North Dakota 14 out of 21 Hill-Burton hospitals had filed to provide their required amount of uncompensated care and nearly 45 percent of their total uncompensated care claims were false.(52) In audits conducted by the Attorney Generals for the states of New York and Massachusetts millions of dollars in unsubstantial hospital claims for uncompensated/free care were uncovered. As a result, 13 hospitals in Massachusetts were required to provide an additional $2 million of free care to low-income patients.(53)

In New York in 1979 out of 152 hospitals surveyed only 62 reported providing at least 10 percent of their federal assistance or 3 percent of their operating budgets in free care, one New York hospital that accepted over $2 million in Hill-Burton funds only $1,989 worth of free care to 7 patients in 1978 and $42,251 to 19 patients in 1979 under the open door option. Another hospital in 1980 chose the 10 percent option but reported providing only $370 worth of free care when its obligations was over $200,000.(54) Given the overall problems of enforcement and hospital compliance to Hill-Burton, it must

be concluded that on site visits by individuals quite knowledgeable on Hill-Burton law would seem to be the only sure way to know whether any Hill-Burton facility has properly complied with its obligations.

FOOTNOTES

1. Public Law 79-725, Hill-Burton Hospital Survey and Construction Act of 1946, Title VI - Construction of Hospitals, Section 621.

2. On this point see Dan Feshbach, "What's Inside the Black Box: A Case Study of Allocative Politics in the Hill-Burton Program," International Journal of Health Services 9 (2) (1979): 313-339.

3. Kenneth R. Wing, "The Community Service Obligation of Hill-Burton Facilities," Boston College Law Review 23 (3) (May 1982): 577-632.

4. For a discussion of the federal government's history in health care see Carleton B. Chapman and John M. Talmadge, "Historical and Political Background of Federal Health Care Legislation," Law and Contemporary Problems 35 (2) (Spring 1970): 334-347.

5. On these points see Patricia A. Brandon, "The Right of Access of the Medically Underserved to Health Care Services." Journal of Legal Medicine Vol. 2 (3) (September 1981): 297-345; 329; notes 113-119.

6. See Michael Balter, "Secret in Health Care," The Progressive (April 1981): 5-7.

7. Title VI of the Public Service Health Act of August 13, 1946, Public Law 79-725, Section 601. The Hill-Burton Act is codified at 42 U.S.C. Section 291 et. seq.

8. Fesbach, "What's Inside the Black Box," p. 313.

9. Public Law 79-725 (1946), Section 622(f), emphasis added.

10. See "Lost Medical Care for Jobless: Cost May Be Health or Lives," New York Times (March 1983), p. 1.

11. See Public Law 79-725, Section 622 (f), 60 Stat. 1042-43 and 12 Federal Register, (1947) 6.176.

12. Even when Congress replaced the Hill-Burton Program with the National Health Planning and Resources Development Act of 1974 these obligations remained virtually intact on receipt of federal funds. The Act as amended in 1979 again left these obligations virtually the same. See Title XVI Public Health Service Act (P.L. 93-641) (1974) and (P.L. 96-79) (1979) Section 202.

13. See DHEW Draft Regulation (for discussion purposes), Services for Persons Unable to Pay (September 1, 1971). Section 53.11 (a) (2)

14. See 37 Federal Register 7632, 7633 (1972).

15. Interim regulations were issued on July 22, 1972 and final regulations were issued on June 22, 1973. See 38 Federal Register 16353 (1973).

16. See Title VI of the Public Health Services Act of August 13, 1946, Public Law 79-725 Section 622, 60 Stat. 1042 and the National Health Planning and Resources Development Act of 1974, Public Law 93-641, Section 1602.

17. See Balter, "Secret in Health Care," p. 7.

18. See 42 C.F.R. Section 124 503 (a) (b).

19. See 42 C.F.R. Section 124 503 (b) (c).

20. Originally, the community service obligation had a twenty year time limit. However, the obligation was held to have no time limit in Lugo v. Simon, 426 F. Supp. 28 (N.D. Ohio 1976). The 1979 regulations were written to comply with this decision.

21. See Clari v. Centre Community Hospital, No. 2900 Philadelphia Superior Court, July 15, 1983).

22. The separate but equal language was added to the legislation out of deference to Southern custom. See Oscar R. Ewing, "The President's Health Program and the Negro." Journal of Negro Education 18 (Summer 1949): 436-443; U.S. Commission on Civil Rights, Equal Opportunity in Hospitals and Health Facilities: Civil Rights Under the Hill-Burton Program (Washington, D.C.: Government Printing Office, 1965); Newman et al, Protest, Politics and Prosperity; and James L. Curtis, "Civil Rights in Medicine." Journal of Public Health Policy 1 (2) (1980): 110-120.

23. Simkins v. Moses H. Cone Memorial Hospital, See 211 F. Supp. 628 (M.D. N.C. 1962); 323 F. 2d 959 (4th Cir. 1963); cert. denied 376. U.S. 938 (1964).

24. On this point see Wing and Rose, "Health Facilities and the Enforcement of Civil Rights."

25. American Hospital Association, Hospital Statistics, 1979 (Chicago: AHA, 1980).

26. 323 F. 2d. at 963.

27. 211 F. Supp. at 633.

28. 323 F. 2d. at 959-967.

29. On this point see Marilyn Rose, "Federal Regulations and Services to the Poor Under The Hill-Burton Act: Realities and Pitfalls." Northwestern University Law Review 70 (1) (March/April 1975): 168-201.

30. See 37 Federal Register (1972) 14719; 40 Federal Register (1975) 46203; and 44 Federal Register (1979) 29372.

31. See U.S. Department of Health, Education and Welfare. "Final Background Paper on Health Care and Civil Rights." Presented to the U.S. Civil Rights Commission (April 1980).

32. See Institute of Medicine, Health Care in a Civil Rights Context.

33. DHEW issued its 1972 regulations as a result of a number of court rulings which held that individuals have a private right of action to sue under the Hill-Burton Act even in absence of specific authorization in the Act. See, for example, Cook v. Ochsner Foundation Hospital, 61 F. R.D. 354 (E.D. La. 1972) and Euresti v. Stenner, 458 F. 2d 1115 (10th Cir. 1972). The 1975 and 1979 regulations were also brought about by court decisions. For example, see, respectively, Corum v. Beth Israel Medical Center, 359 F. Supp. 909 (S.D. N.Y. 1973) and 373 F. Supp 550 (S.D. N.Y. 1974), Gordon v. Forsyth County Hospital Authority, 409 F. Supp. 708 (M.D. N.C. 1975) and Newsom v. Vanderbilt Hospital, 453 F. Supp. 401 (N.D. Tenn. 1978). Litigation preceding each set of new regulations attacked both DHEW and Hill-Burton hospitals for lack of enforcement and implementation of the uncompensated care and community service assurances.

34. Hospital Center at Orange v. Cook, 177 N.J. Super. 289 (App. Div. 1981), 426 A. 2d 526.

35. See Armin Freifeld, "Hill-Burton: The Shape of Today and Yet to Come." Clearinghouse Review (November 1981): 567-573.

36. See AHA v. Harris, 477 F. Supp. 665 (N.D. Ill. 1979). Interestingly, the American Hospital Association played a major role in both supporting and writing the first draft of the original Hill-Burton legislation of 1946. See Wing, "The Community Service Obligation of Hill-Burton Health Facilities," p. 593, note 64.

37. AHA v. Schweiker, No. 82-1295 (7th Cir. November 1, 1983).

38. Two organizations intervened on the side of DHHS: the Legal Assistance Foundation of Chicago and the National Health Law Program.

39. Cert. denied sub. nom American Hospital Association v. Heckler, 52 U.S. Law Week 3791 (May 1, 1984).

40. See Gordon v. Chattanooga-Hamilton County Hospital, No. 1-82-512 (E.D. Tenn. July 5, 1983) (final order).

41. See Moore v. Ellis Hosp., No. 80-CV-79 (N.D. N.Y. June 15, 1983) (consent decree).

42. See Citizens for Equal Health Care v. Tuality Community Hospital, No. 82-664 (D. Or. August 3, 1983) (Consent decree).

43. Wyoming Hospital Association v. Harris, 727 F. 2d 936 (10th Cir. 1984).

44. Health Advocate, No. 141 (Summer 1984), p. 1.

45. See 49 Federal Register 15880 (April 19, 1984).

46. "Health Care for the Poor During 1983: A Time of Reassessment and Transition," Clearinghouse Review 17 (January 1984): 976-1000.

47. Ibid., p. 985.

48. See Hearings on H. R. 6084, H.R. 6173, and H.R. 4554 before the Subcommittee on Health and the Environment, Committee Energy and Commerce, House of Representatives, 97th Congress, 2d. Sess. 589-629 (1982).

49. Ibid.

50. See "Health Care for the Poor During 1983," p. 985.

51. Ibid., p. 985.

52. O'Neil, "Site Visits at 21 Hill-Burton Hospitals," Clearinghouse Review, 16 (1982): 404.

53. See New York Attorney General, "Serving the Medically Indigent: A Report on Hospitals' Compliance in New York with the Federal Hill-Burton Act" (Office of Public Information-New York State Department of Law, June 1983) and "Health Care for the Poor During 1983," p. 985.

54. New York Attorney General, "Serving the Medically Indigent," p. 22.

RESEARCH AND POLITICAL PERSPECTIVES

POLITICAL:

Gloria G. Lawlah, M.A.T., Member
Democratic Central Committee of
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I am not speaking as a professional although we might think of ourselves as professional consumers. We often do not act that way, because we probably do not have the information we need to take advantage of being a professional consumer.

Presently I would like to term myself as a housewife, a lady next door to you, a community resident who is now involved in a state and local problem. Believe me you learn about these things in a hurry, although we are distant from the halls of academia to the halls of the state legislation where the bills are passed that affect our everyday lives, regulate the health care industry, and provide millions of dollars in services for some people.

Ordinarily, if you and I really think about health care, we are providers of academia. Many of you have programs where you groom a person to become a provider; but, ordinarily you do not think about health care. You really do not think about it until you get sick or until somebody in your family becomes ill or perhaps someone that you love or care for gets injured. When any kind of problem develops, then you become the consumer; and if you ever go through the Emergency Room of a hospital, you know that when you get there they want to know if you are paying. Are you a paying patient? That's what is important to them.

The second key question that I would like to pose for you is, what are some of our responsibilities to minority communities in terms of providing health care? If you are, in fact, in academia you should be involved in some of these processes to insure quality health care. I say that because I have just been awakened to this fact; and I am finding out that the health care industry is one of the fastest growing industries in the United States, and it spends money.

Recently, I was fortunate enough to run across a policy called two-tiered health insurance. I am sure most hospitals would not like to take you off a two-tier or multitier health program, for it has been here for a long time. They are now saying that it is good to offer two-tiered health care. The two-tiered health care system, I suppose, comes in two groups. And those two groups are (1) persons who are unable to pay and do not have insurance, and (2) those who are able to pay. A 1984 survey of health care users found out that

sixty percent of those persons believe that a low quality of care is provided by public hospitals. I would like to challenge you with this question. Is it worse to go to a public hospital such as D.C. General, or is it preferred to go to Georgetown, George Washington, or one of the other nospitals that might be perceived to provide a higher level of health care?

Recently I was appointed to a particular board for one of the nospitals. At one meeting, I sat there in amazement as we talked about profit. We have a health care policy for the aged; we are talking about the feeling here in the United States that persons from middle to upper incomes will not come to our center even though our center is new. It is sparkling new; we have some of the best health care providers. I think it is probably one of the top rated hospitals. In terms of cost, we do know that Political Action Committees now are controlling almost every person in the director's office; and it is going to get worse especially at the congressional level, and the state level. Can you think of any person or any group in the health care field that has powerful political action committees? Can you think of one that ranked number four or five in the nation, or at the very top in terms of employing them to elective office at the congressional and state caucus? When you sit on a hospital board, you participate with doctors and consumers coming from the community. The doctors, however, have a great control over what happens; and this determines who goes to make the laws. At the state and local levels in my county, in the state of Maryland, there are 13 Blacks elected to the state level. Seven of those Blacks are elected to the Democratic State Committee; only six are elected to make laws. Statewide, we have a very low percentage of Blacks elected to make laws. Therefore, we have to collaborate with the majority to get laws that will help us.

Before I knew this, I thought that our elected officials would do the job. However, because we now have representation on the State Committee, we have an opportunity to get some input at that level. We have a Health Systems Agency in South County which controls four counties. The policies made by these four counties are made to advise the state legislature and the governor on what should happen in those four counties. That agency has 30 slots: 16 of those slots are for consumers, such as yourselves and 14 of those are for persons of the medical professions.

So it stands to reason, you have to make an impact in electing a person to office. It is important that you who are in the halls of academia get out of there sometime and look at the real world to note whether an elected official is making a real impact; then you know whether you should help this

representative get back in office. A lot of times we say, "well, there are politicians and bureaucrats over here, what should I vote on; I'm just one person, what can I do for the laws?

Let us go back to the legislative process to discuss what the people at the state level are responsible for. Once they are elected to become a delegate to the Senate, they pass all laws necessary for the welfare of the citizens. All regulations come from that source. Therefore, I ask each one of you, do you know your state senator? Do you know the congressman from your district? Do you know how much money they make? Do you know who your person is in the House of Delegates? They will often come back to the local level to talk to you; but you need to really know these people. The women elected in Maryland in August of this year will hold a small tea party conference in Delaware, Maryland, and they will invite you to come to talk about your concerns in any area. At the convention in August, we were invited to come and speak to the Maryland legislators who are women. We were invited to tell them what we perceive to be the health care needs of our people; we have input at that level. I feel that we all have a responsibility to get involved in the process of something. You can talk with your sorority, your fraternity, your church and members of your community to start identifying the needs in your area. Black people do not have any money. We cannot have a P.A.C. We do not have that political action money of 3 to 5 million dollars, but we have numbers. So, we pull those numbers together, and then we have got to raise money, because every candidate needs money. Even representatives at the local and state level need money. Candidates need lots of money to go back to Congress and if the candidate is friendly to us, then we do want to send him back to Congress.

You are going to elect these different people to office, and once they get in office, then you must lobby your lawmaker. They will in turn appoint you to hospital boards and to the health care agency board. In our last election we elected a democratic governor. Once elected, he did not forget us; he appointed one of our White women to become Secretary of State. She, in turn, came back to the Black community and this had never been done before.

In conclusion ladies I want to say that we can do something about the two-tier system. We know that the Blacks and poor people suffer from this two-tier system. If you have money, you can buy anything in America. Those of us who are recipients do not want to "rock the boat" although it affects everything that we do. Meanwhile, we should have a coalition band together to talk to our elected official about what we want. We must have the voters there to say to these officials, "these are our needs, and we want you to respond properly to Congress."

HEALTH PROMOTION/DISEASE PREVENTION IN MEDICALLY UNDERSERVED AREAS

REMOTE SITE TRAINING: THE DELMARVA/AHEC MODEL

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The Western Tidewater Area Health Education Center (WTAHEC) sponsors an annual, summer interdisciplinary health science student training experience with Delmarva Rural Ministries, (DRM) federal grantee for primary care service to the migrant population on the Eastern Shore of Delaware, Maryland and Virginia. The Eastern Shore is separated from the mainland by the Chesapeake Bay and connected by the famous Chesapeake Bay Bridge Tunnel. WTAHEC, rural satellite of Eastern Virginia Area Health Education Center, enjoys contracts with Eastern Virginia Medical School, Virginia Commonwealth University/Medical College of Virginia--Schools of Dentistry and Pharmacy; Hampton Institute, Department of Nursing; Old Dominion University--Departments of Nursing and Allied Health; and Norfolk State University--Departments of Nursing and Allied Health in southeastern Virginia. Working with faculty coordinators from these various academic institutions and DRM staff, WTAHEC staff orient, schedule and evaluate bimonthly rotations for medical, nursing, dental, dental hygiene and medical technology students during the months of June, July and August. Each institution has established the rotation as a part of their educational curriculum and recruits students annually while WTAHEC houses and reimburses students for meals and transportation. The students are able to improve their clinical skills while working in Delmarva's Clinic, the public health dental trailer, the migrant labor camps, day care projects and summer school programs for the children of migrant farm workers. They are exposed to the multifaceted delivery of primary health care to an underserved population in a rural setting. A unique feature of this rotation is the bimonthly interdisciplinary case conferences where students must address the topic from each discipline's perspective and concur on a care plan for the patient presented in the conference.

This project grew out of the expressed need for dental students to participate in an extramural rotation in the Eastern Shore of Virginia in the summer of 1982. In that year, two medical technology, two dental hygiene and two dental students worked together with the DRM staff at their

Nassawadox, Virginia site. Subsequent summers and better organization have seen 59 and 72 student participants in 1983 and 1984 respectively. Refinements in the project have been to establish an on-site student coordinator and to expand the rotations to the Maryland and Delaware sites. Currently, course outlines and project objectives are being reviewed by the DRM staff coordinators and preceptors at each site. Evaluations from students, faculty and staff are being used to plan for the summer of 1986. Special attention is being focused on the orientation of the students to improve student understanding on the uniqueness of the client population and delivery site. Future plans include development of a course in cross cultural health care delivery to be offered as a prerequisite to the actual rotation.

Concurrent to the ongoing planning and implementation of the rotations, is the development of a national demonstration project on the Delmarva/AHEC experience. A 20 minute videotape has been professionally prepared on the actual student experiences, and a manual is being prepared for migrant health clinics and academic institutions. Plans are to market this model program to targeted migrant health projects in 1986.

The key to success of this project is the trust and sensitivity the DRM and WTAHEC staffs have developed. Because the migrant season is so high in work volume (5,000 patient encounters per season), the planning and preparation is done "off season." Where there is not good communication between faculty, students and staff, the students have suffered, usually in their expectation of the experience. But because this training site is so rich in culture diversity, atypical health problems, an outreach delivery system, and an interdisciplinary approach, the students ultimately return having had one of the most unique experiences of their health science education.

HEALTH PROMOTION/DISEASE PREVENTION IN MEDICALLY UNDERSERVED AREAS

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The intent of my very brief synopsis, is to give you some ideas in terms of the Area Health Education Center application or the AHEC concept in health professions training. Currently, there are 18 states in the U.S. that are funded through the federal government to conduct AHEC programs. There are now three minority oriented institutions within three states that are funded through the AHEC. They are the Charles R. Drew Postgraduate Medical School, located in Los Angeles, which is a part of the statewide AHEC system in California; Meharry; and Morehouse Medical Schools. Meharry and Morehouse were recently awarded AHEC funding in November, 1984. There are about 14 different program areas that the AHEC address, the overall goal being to improve the supply, distribution, efficiency, and quality of health personnel in medically underserved urban and rural areas. The Drew/AHEC serves a medically underserved urban area.

Every medical school in the state of California is a part of the statewide AHEC system. The AHEC system is the major health manpower initiative currently going on in California. All of the UC Medical Schools have AHEC's as well as three private medical schools. Those private medical schools are Loma Linda University, USC Medical School, and Stanford University Medical School. The Drew AHEC is conducted under the aegis of the UCLA School of Medicine since the Drew School is still not a full four year medical school. We have an undergraduate M.D. program as of 1981, in fact we're getting ready to graduate our first class of MD's. And the way it works is that the first two years of medical school, the basic science years are done at UCLA, and then our Drew/UCLA medical students come to the King/Drew Medical Center for the remaining two years which are the clinical years, the third and fourth years.

The Drew School has been a part of the AHEC System since 1979. Currently the Drew AHEC Program is in its sixth year of operation. The average lifetime for an AHEC center is six years.

Ms. Donzella Lee talked about the demographics of the service area, so I won't go into that. I will say that Watts is within the Drew AHEC Service area. The Drew AHEC Service area is approximately 144 square miles. It has a population of about 1.5 million people in the service area and includes the

communities of east and west Compton, Inglewood, Lynwood areas, South Gate, the periphery of Long Beach.

The Charles Drew Postgraduate Medical School is the academic arm of the Martin Luther King, Jr. General Hospital. We have about 14 residency training programs that house approximately 230 residents. We have approximately 160 faculty, and a number of community service programs that support the programs that train health professional students. We also have a physicians assistant training program. We now have an on site Bachelor of Science Nursing Program, one of a number of Health Professions Training Programs, which the AHEC Program directly impacts.

Two very important program areas are health promotion and clinical nutrition. Two key words in the mission statement of the Drew School are training with "competent and compassion" health professionals will ultimately serve the medically underserved. The goal of he AHEC is totally in sync with the overall mission of Drew School. In the demographics of the service area the ratio between the primary care provider/patient is one primary care practitioner to every 3200 people in the service area, as opposed to the overall ratio of the Los Angeles area one practitioner to every 650 people.

These statistics were developed a few of years ago, and the Hispanic population overall in southeast Los Angeles is greater than the Black population at present. The "other" category that Donzella Lee was talking about is our Asian descendants; there area number of Philippino, Vietnamese and Samoan citizens in our service area.

Major causes of death and disease in our service area are cancer, heart disease, stroke, and infant mortality. At present, our service area has shown a significant rise in the incidence of gang related deaths and injuries. There is also a lot going on in terms of domestic violence and homicides related to the sale of drugs in our service area.

The Martin Luther King Hospital is located across the street from Drew Medical School. It is a 404-bed facility which all of our health professions students rotate through.

King Hospital Center opened its doors, as well as the Drew School, in 1972. The institution has had a history of involvement in health education. Mostly, the involvement focused on the management of chronic illness in addition to pre and postnatal related care.

King-Drew health education programs have always used the strategy of learning by doing. It is a very practical

application in terms of fully digesting what is being taught. The primary care departments typically have had at least one health educator on staff. There has always been administrative programs at the institution.

1976 marked an important milestone, and that was the institution of the Department of Family Medicine. A residency training program of family medicine was instituted by Dr. David Satcher, who is currently the President of Meharry Medical School. It was an important milestone because based on the assessment that Dr. Satcher did, to see if there really was a need for a residency training program in family medicine, the assessment revealed the need for postgraduate training in family medicine to learn principles of health education. Dr. Satcher's philosophy of why patient education should be a part of graduate medical education comprised the following idea: Patient education programs should not replace teaching and communication between resident and patient. It should, however, enhance doctor/patient communication and impart skills to students in patient education. These skills would be used in their own future practice, after they have completed the program.

Dr. Satcher drew from his review of existing studies. The benefits of patient education included improved utilization of services, better patient compliance, fewer hospital admissions, earlier discharge, decreased use of emergency rooms, and most important, the containment of health care costs. A great amount of the educational methods conducted even now at King/Drew Medical Center is in the context of patient education classes, as well as on an individual basis.

Objectives of patient education in residency training:

1. identify the educational need of the patient and the necessity for specific knowledge and skills to ultimately develop programs which would best meet the need of each individual patient;

2. prepare residents to include patient education during the provider-patient encounter;

3. appreciate the usefulness of various techniques and methods by exposing the resident to strategies for lifestyle change for the population served;

4. recognize the need for evaluation and research patient education;

5. promote the concept of physician as teacher, advisor, as well as healer, and role model. If you don't feel and live what you're teaching, then you

are going to be ineffective.

The content of curriculum which focused on managing the chronically ill and medical self care was instituted in 1976. There are milestones that we have reached with the inception of the AHEC Program. In 1982, the health promotion clinical nutrition component was instituted via the AHEC Program. The Drew AHEC introduced the discipline of prospective medicine into the curriculum. This concept examines certain age and ethnic groups to look at the probability of death and disease based on lifestyle. It offers a prospective outcome of what is likely to come about instead of what has already happened to impair individual's health. It looks at the diseases and conditions that are potential causes of death. We examine the Geller tables with our health profession students; the Geller tables essentially gives you an ethnic breakdown, and it gives you years. Let's take for example the Black male. From the ages of 15 to 20, for example, the Geller table will tell you the likely cause of death for that particular age range, sex and ethnic group. And based on that assessment, health promotion programs would be planned to reduce health risks among this specific population.

The AHEC Program is now organized under the School of Allied Health. At present, the AHEC is assisting the new school in the formulation of state policy that relates to the training of allied health students in the discipline of health promotion. The AHEC Program is working very carefully with Allied Health administration also to establish undergraduate programs in health services administration and dietetics.

In conclusion, it is the contention of the School of Allied Health, Drew Medical School, and the AHEC that these kinds of activities will further enhance and improve the status of health in our service area. One additional point that should be made is the importance of partnerships and networking with other institutions in our service area. We are finding that in terms of having quality health promotion programs, it becomes a challenge. All of us have situations where we are having to look at our programs, and they are not attended or you do not have consistent attendance or issues come up in your patients' lives because of the type of service area you are dealing with; health promotion becomes less of a priority. We are finding that in order to have quality programs, the King/Drew Medical Center must partnership with other institutions to establish health promotion initiatives that are fully accessible to community citizens. An example of that is a partnership that exists between the Drew School and the YMCA. At present the Drew School is rotating physician assistants through this center, in order to work more closely with community service agencies.

HEALTH PROMOTION/DISEASE PREVENTION IN MEDICALLY UNDERSERVED AREAS

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Consolidated interdisciplinary health promotion and disease prevention services and programs for high-risk young people in the District of Columbia are further being developed and addressed by the College of Allied Health Sciences, Howard University, cooperatively by Howard University Hospital, the Department of Human Services and the Center for Youth Services through the neighborhood based "Fifteen to Twenty-four Evening Center" and the Center for Youth Services. Participating personnel from Howard University and the sponsoring agencies include health professionals, students, support staff, volunteers and advisory board members who are complimented by grand funded personnel.

As the availability of new knowledge related to the principle and practices of health promotion and disease prevention are imparted to selected allied health professionals, primarily those with the greatest potential to influence health related behaviors at the primary level, those concepts are incorporated into the curricula of allied health education. Comprehensive health promotion and disease prevention are then directed by faculty and students affiliating through the health stations of "15 to 24 Evening Center" and the Center for Youth Services.

Five primary care non-physician provider groups were identified that provide health promotional and disease prevention principles; physician assistants, nutritionists, physical and occupational therapists and medical technologists. These disciplines specifically address the health needs of the population in or outside of the catchment areas, and in particular, teenage and young adult pregnant women and recently their subsequent infants from birth to three years of age.

On-site services include primary care prevention (appropriate in the stage of susceptibility) or reducing exposure for susceptible individuals. It is commonly accepted that primary care consists of a particular set of services, provided by certain types of health professionals, addressing general health problems in ambulatory settings.

On-site health and health related services include comprehensive adolescent medical care including, but not limited to, venereal disease screening for males, development and behavioral assessments, genetic counselling, nutritional assessment and counselling, stress reduction and physical exercise class for adolescent and young pregnant women, family planning, mental health services to deal with the problems of emotional disorders, substance abuse including counseling and health education sessions.

I think that medical technology did not lose sight of the fact that they still had something that they could do. So at this time they have been transferring students from medical technology; they go out and use a broad approach not only to sharpen their skills in telling about diseases, by using slide presentations, etc., but they have permitted the young people to have a hands-on type of approach to using equipment. I think some of those that have been discussed were in the sexually transmitted diseases which, by the way, in the boards that we serve (groups five and six in Washington) they have a three times higher than the national rate for sexually transmitted diseases. But I don't kid you, it has been difficult because from the population that is being served we get a broad spectrum of young people, not just poor Black kids. We are having young people come in that had extremely high motivational levels, that are in school, and they want to pursue a dream. The centers themselves offer a variety of packages. There is job counseling; there are exercise programs; and, by the way, our own physical therapist came up with a stress reduction and physical exercise program for pregnant adolescents and young women. And so for these types of activities to have good role models is still very important for young adults, and/or children.

In addition I think we were supposed to bring out the fact that come this fall because of the size of the constituency, not just the patients, but our students, our faculty, and other faculties that we have great influences on are you yourselves. Only nine schools received the type of grant that we got, and we hope that by fall we will be in a position to offer our workshop. We would encourage other faculty and providers and clinicians from the historically predominantly Black institutions joining with us. During the second week in April you will be receiving our first newsletter coming out of the College of Allied Sciences at Howard University, and we hope to share this with you, not only modulars that we have developed, but different types of approaches that can be used and have been used at the centers.

HEALTH PROMOTION/DISEASE PREVENTION IN MEDICALLY UNDERSERVED AREAS

THE HEALTHWORKS STRATEGY

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It is a pleasure to be here today. Ron Braithwaite asked me to spend a few minutes talking with you. After thinking about what he said, he came back and said make that ten minutes, because in Virginia a few minutes can last an hour. So, in ten minutes, I want to tell you about some programs that we have developed during the last four years, programs we are excited about and we think are making a difference. When I say we think, it is because we don't know. It is too early in the game to evaluate definitively what we call "The Healthworks Strategy." Healthworks is not a particular program, rather it is a strategy aimed at providing low cost, accessible programs to the medically underserved population through their local schools, churches and social organizations. This really has four components that are valid in most urban areas where there are lots of local resources but they are inequitably distributed.

The first component of the Healthworks Strategy is the use of existing organizations and resources. When we looked at medically underserved communities, we felt like there was not a need to go in and create new organizations, rather there was a need to better use the schools, churches, social organizations and businesses that were already in the communities. We also quickly discovered what anyone in the field discovers, there are a lot of agencies, such as the American Heart Association, the American Lung Association, the American Cancer Society, the Food and Dairy Council, and Triple A, the Automobile Association, that have developed extensive health promotional materials. These organizations invest millions of dollars developing materials for public use. Blue Cross/Blue Shield has packets of information on stress management, nutrition and exercise which they make available to the public. These agencies' health promotion materials are, however, underused.

The second part of our strategy was to convince the existing community organizations to expand or redefine their mission to include sponsoring health promotion programs. In the schools, we argued that teachers needed to be more active in helping their students adopt healthy lifestyles because healthy students are better learners. The argument breaks down a little bit when we talk to pastors about the quality of souls

they would be saving. We could say that the parishioners would be healthier and have more time to do more good. Also, we talked about the holistic human relations. Churches should be concerned about their members mentally, physically, and spiritually. In businesses, we made the argument that healthy workers are more productive. We noted that the average cigarette smoker spends about two and one-half minutes lighting, smoking and putting out a cigarette. Depending upon how many they smoke, smoking workers could spend 45 minutes a day simply in the activity of smoking. That is approximately 1/8 of the normal work day. Using a $20,000 salary as an example, a smoker wastes $2,500 in addition to which are the added health care costs they will incur. When we approached these organizations, we said we do not want you to redefine your mission and become health providers, but you ought to add to your mission statement a section that emphasizes promoting healthy lifestyles among your employees.

The third part of our strategy was to recruit and train volunteers in these community organizations. We found a large number of willing volunteers? We trained them to do two things:

1. To obtain low cost and free materials. We talked about all the resources available in the community and we compiled and distributed an audiovisual catalog that lists some 1500 health related films available for free use by the public.

2. To use these materials and to motivate other people to adopt healthier lifestyles.

For example in a classroom, we helped volunteers develop teaching examples which would affect students. One example noted that the Datsun Z car is very popular, something that a lot of students aspire to own. We did some calculating and pointed out that if the students would save over a 10 year period the amount of money that they would spend smoking three packs of cigarettes a day, that they would accumulate nearly enough to buy a Z. The trade off was that they wouldn't smoke to buy a Z. We came up with a lot of other examples all of which emphasized the fact that students have to make choices and that you can motivate them by clarifying the choices they have to make.

The fourth part of the healthworks strategy was <u>providing professional support for the volunteers</u>. Peninsula AHEC is an educational program and works continually with health profession students as well as practicing health

professionals. If the volunteers needed assistance, they could call on us. We could then arrange for a nursing student to help them conduct their program, or a social work student, or a nutritionist or a medical student, or a dental student or anyone else who might be needed. We also provided audiovisual materials some of which we had developed and some we had purchased. We also tried to disseminate current information.

These are the four components of the Healthworks Strategy: using existing organizations and resources, convincing them to expand their mission, recruiting and training volunteers in these organizations, and providing professional support.

What are some sample programs that we have done? We have done television programs. We developed a 16 hour course aimed at kindergarten through sixth grade public school teachers that informed them about materials available through AHA, ALA, ACS, etc., and that showed them how they could use these materials in their classroom to promote healthy behavior. At first, the teachers were afraid that they would have to learn a lot of new information or spend a lot of time doing lesson plans. We said, "No, it is already done. And, most of the time it is in your school, you just do not know it is there." Once we designed the program, we broadcast it over a television network that went right into the school system. The teachers could stay after school and take our course. They could take it for either college credit or non college credit and it could count toward their certificate renewal. We required two activities in addition to watching the television course, which we thought were very important. First, we required that they attend workshops where people from the Heart, Lung, Cancer and other health organizations demonstrated their programs. The organizations brought their materials and physically handed them to the teachers at the workshops to take back to the classroom. Second, in order to receive credit for the course, the teachers had to sign a contract with their principal to deliver 20 hours of health education programming in the classroom. We did not require that these be "new" hours. For example, we were very interested in having teachers use math problems and readings that dealt with health. Rather than counting the number of fighter planes, garbage trucks, and beans in a jar, students could work on problems that had to do with health, such as the incidence of
disease based on different behaviors. The bottom line is that we developed a television course that is currently affecting 250 teachers, about 7000 students, each of whom now gets 20 hours per year of health promotion. From a student perspective, that works out to 140,000 hours of health education that is now available, and that wasn't available before.

A second program that we have been doing concerns churches and

social clubs where we volunteer to take the blood pressure of their members. This program involves a six week training course lasting two hours per week. Upon completion of the course, the volunteers screened all the members of the church or the organization. So far, this has involved about 30 volunteers and 500 members of community organizations.

A third program is a health forum in which we conducted a course with people spending one day a month for six months to learn about health promotion. The objective is to help businessmen learn what health promotion is, what difference it makes in the work place, and how to evaluate the variety of programs that now appear in the marketplace so that they can purchase useful programs for their employees. To date, we have had 12 volunteers who attended our six month forum. They represented employers with employee population of over 50,000.

What problems have we encountered in implementing this strategy? I will list four that I think are the most important ones. First, each of these organizations has other agendas that are important. Health promotion, while important to churches, is not their major mission. Health promotion, while important to schools, is not their major mission. It is a constant battle once we have gotten an organization to redefine its mission to get them to pay attention to something that is a lower priority. A second problem is that we have found that lots of organizational leaders have unhealthy lifestyles. It is interesting but ineffective to have someone who is 50 to 75 pounds overweight and a chain smoker stand and espouse the attributes of a healthy lifestyle. We encountered the problem of people being committed conceptually to the program because it was good for everybody else but not for them because they liked their salt and they liked their cigarettes.

The third thing we ran into is most charitably described as the emergence of unnamed critics, people who anonymously criticized what we were doing in terms of, "It is not appropriate for the church or the school or the business," or "They are not doing it the right way," or "They used one set of materials rather than another," or "What we said was different from what their physicians told them." Yet, these unnamed critics were not willing to identify themselves sufficiently to get involved in what we were doing and help us improve. They simply wanted to criticize.

Fourth, there was a problem with "evaluators." These are people who wanted an extensive scientific evaluation to tell them that what we are doing makes a difference, that in fact children were better learners, that members of churches were better congregation members, and that workers were more productive. Yet, they were not willing to give us money to

conduct the evaluations to answer those types of questions. They would say, "Well, here is one hundred dollars, go evaluate this program." We can't study people's lifestyles, our programs, and learn what difference our programs made with one hundred dollars. We could not do this study for one person, let alone several.

Overall it is too early to tell whether the Healthworks Strategy is successful. We have increased health promotion activities in the classroom, in the churches and in businesses. We know anecdotally of people who have stopped smoking, of people who have reduced their sodium intake, of people who have begun exercising. We know there have been changes but cannot quantify how much of that change we caused and how much better off people are because they changed. We have used the Healthwork Strategy continuously for the past three and one half years. We are beginning to see some results, but it is far too early to document the full consequence of what we have done.

HEALTH PROMOTION/DISEASE PREVENTION IN MEDICALLY UNDERSERVED AREAS

Donzella Lee, M.P.H.
Project Coordinator
Watts Health Foundation
Los Angeles, California

I represent the Watts Health Foundation, which is currently a prepaid health plan in Watts, California, and I will be speaking specifically about one of our institutions within the United Health Plan, which is the Watts Health Center, located on 103rd Street and Compton Avenue, in the heart of Watts. I would like to give you a introduction to the kind of patient hospitalizations that we now service.

We have approximately an 85% Black population, 14% Hispanic and 1% other, what that other is, we do not know. Watts is surrounded by three major housing projects, and I am going to talk more about that in the whole perspective regarding some of the health promotion activities that we do. The McCone Commission who initially studied the Watts Riots just met again and reassessed some of the areas that were assessed in 1965 after the Watts Riot. The report was exactly the same; as a matter of fact, many of the problematic issues that were identified, unemployment, education, and housing, are still prevalent. So I do not know what is happening in terms of some of the things that they have been doing, but the outlook is not good at all.

The Watts Health Center is a primary health care facility that provides a variety of health services, such as OB/GYN, pediatrics, and internal medicine. All laboratory services are provided on site, such as X-ray, dental, and outpatient services. These services are provided by a variety of medical practitioners, nurses, physicians, doctors, health educations, P.A.'s, M.P.'s, social workers, P.T. We have a wide gambit of health professionals at our site.

Another factor is that because of our location, much of our statistical information includes the entire South Central Los Angeles area; some of the information I have given you is inclusive of the Watts area and South Central Los Angeles.

In 1983, more than 20 out of every 1000 babies born in Watts died because of birth defects compared to 10 out of every 1000 countywide in Los Angeles. And I think that these death rates are applicable to most underserved areas and minority populations. Therefore, we are going to reasn many of the

same facts that are applicable to similar socio-economic environmental communities.

We have a 40 percent unemployment rate for your Black males in the Watts area which may contribute to the high level of gang activities. We have at any one time a 30 percent absentee rate in the schools. Our medium education level in the Watts area is 10th grade. We have one of the highest incidences of substance abuse, homicide, and violence. You name it, and we have it. We have the highest rate in the County of Los Angeles of teenage pregnancy. Young Blacks account for a large percentage of the overall crime rate. The death rate has been increasing in Los Angeles County as a whole, but the average is four times higher in South Central Los Angeles.

This gives you a picture of some of the issues and factors that must be taken into account when we design health promotion programs. We do not approach health promotion from the traditional perspective because we consider the socio-economic and psychological factors that our clients are confronted with on a daily basis.

Therefore, I would like to describe to you some of the programs we currently have in the Watts Health Foundation, and after that you can ask questions in regards to these programs.

We have an Adolescent-Adult Information and Education Project that is coordinated with the schools, and we also work with pregnant teens. We have a Maternal and Child Health Program whose primary focus is to educate mothers in the area of prenatal and postpartum care. We have a Sickle Cell Disease Program also. What I would like to emphasize regarding the spectrum of health promotion programs is that they impact upon all levels: primary intervention, secondary and tertiary. This was a conscious strategy implemented to meet the needs of our patient population. We have hypertension education programs. We have diabetes programs, and we have nutrition programs. One of the most unique things that we are doing right now in regards to nutrition is that we have a program that has input from our WIC program on which I hired teens to implement the educational components, and a social service agency in our community entitled El Nido, which is staffed by social workers. The purpose of the program is to increase the parenting skills of teen mothers.

We are implementing cancer prevention and smoking cessation programs. In our smoking cessation program, we have implemented a cooperative community education model. We are working in conjunction with the King/Drew health educators to implement a series of smoking cessation programs in our community.

We are implementing a prenatal education program targeting addicted women within residential and outpatient settings. We have an enormous number of mothers who deliver who are addicted to a variety of substances. The main drug that our clients are abusing is cocaine; secondly, PCP. Therefore, we are working with our pregnant mothers to see if we can improve outcomes in terms of their pregnancies; i.e., average birth weights, less physical impairments, improved parenting skills, and well baby care skills.

We have a youth intervention program in the area of substance abuse at the elementary school level. We have an Adult Day Health Care Center that employs a variety of health promotion activities. And one of the activities that we are implementing on a daily basis is closed circuit television within our facility to those patients who are waiting for medical services in each "waiting room" four hours a day.

I believe that special populations require special programs, particularly in medically underserved areas; I think that we should employ all of the different kinds of creative ideas that we can generate. I believe that in our outreach efforts we have to include all populations in health promotion programs; in California we call them Risk Reduction Programs. We have to design outreach techniques that are appropriate and employ the best kinds of marketing strategies. We have to provide content information that is pertinent and applicable to their daily lives. People must have "useable" information. Many pragmatic efforts have given people a lot of information that they cannot use. I think that role models, positive, caring, believable role models are necessary to have successful programming.

We must talk about lifestyle changes in terms of small steps that are advantageous so that people do not drastically have to change their lives. And we have to look for behavior outcomes that reflect these lifestyle changes and simultaneously educate the people who are funding us to look for appropriate outcomes.

The last concept that I would like to discuss in terms of health promotion/risk reduction programs is that we have to give people some skills within our programs. If we don't give them skills to use, then our programs are of no benefit to them. And when I say skills, I mean skills they can look at and say, "I have gotten something out of this program," if it is no more than learning how to be a nurse's aid, or learning how to take a temperature, or how to take a blood pressure. These skills are more concrete and will aid them in appropriate decision making behavior. We have to structure skill development within the programs.

So I have some challenges for all of you in the audience. Our challenges in the area of health promotion are: First, giving information that is useful. Second, we have to effect the political system which states that health promotion and disease prevention programs cannot work in medically underserved areas. That is the kind of climate that we have in California. We have very little money designated to medically underserved areas in the area of health promotion and risk reduction because the state believes our population is too sick to effect any changes. Third, we need to develop programs that will address the health needs, not only in terms of physical health, but psychosocial and emotional needs of the client. Fourth, networking is a must, and when I say networking, I mean sharing information, sharing resources, and implementing joint programs that effect a change within the community. We have to advocate for these things politically, as well as to use existing standard agencies like American Red Cross, to make programs applicable to our needs, because many of those agencies do not know what we need. We have to have non-health related agencies involved in our efforts, including churches and YMCA's, Boy's and Girl's clubs. And lastly, we have to develop a resource base to allow us to continue our programs.

HIGHLIGHTS OF CONCURRENT SESSIONS AND SPECIAL INTEREST GROUPS

DEANS AND DIRECTORS OF ALLIED HEALTH

Andrew Bond, Ph.D., Dean, School of
Health Related Professions
Tennessee State University/Meharry Medical College
Nashville, TN

We, like educators, got right into our business. We talked about several problems that have been recurring at this conference in one form or another. The first issue of concern was the lack of Black males choosing Allied Health careers. We noted that there are some exceptions in Sports Medicine, Physical Therapy and even in some of those programs which traditionally were largely female, such as Dietetics, Nutrition,and Dental Hygiene, male students are now enrolling. We agreed that not only in the Allied Health Professions or Sciences, but in other sciences even in Engineering, from the standpoint of the Black male, we are losing ground. That is not bad from the context of Black females increasing in numbers in many of these professions, but this was a concern and we talked about this one at length.

We talked about students being forced to choose careers at an early age as a result of the magnate school concept trends, and option school. Some of us had some feelings about that. We said that we need schools with good science laboratories. I was in one of those schools; the other school of a few hundred students had a computer for about every three students; and they had good science laboratories. But, it did force decisions on these young people at a very early age, and my experience with Black kids is that they usually don't know what they want to go into until about the sophomore level in college. So if you are going to force them to choose at the eighth or ninth grade, that is a problem.

We discussed the perennial problem of the recruitment of Black faculty and the recruitment of Black students at majority and minority institutions; certainly, we know that there is still a shortage of professionals and practitioners in a number of these areas, and we talked about that and the lack of role models, which is a perennial problem.

Another situation is that too many Black students choose Allied Health as a second choice instead of the first one. I know this is true in my school; students start out wanting to be a nurse and after they are refused admission, they may come by and ask if we would take them in Health Administration or Respiratory Therapy, and in my case, sometimes I do. In fact,

if he is a pretty good student, I will take him, because I have slots. Students interested in Pre Medicine, will take the pre-med course and then about June, they switch to Medical Technology because their scores and grades are not good enough. We talked about that problem. Then somebody brought us to term and said, you are talking about the system, not really the problem. At this point, we got into attempting to talk about what we really perceived to be the problem. And you know that becomes philosophical, and we agreed that it was socioeconomic to some of us. That's just another way of saying blatant racism is still well and alive in this country, and it cuts across all of the things that we have been talking about here, from health care to producing practitioners, educational programs, and so forth. We talked about the public school systems and the fact that White flight to the suburbs is leaving undersupported, poorly paid teachers, and undersupported inner city schools.

We spent a lot more time talking about problems and recommendations. We did agree that the problems are complex and very complicated and that we should talk about strategies, techniques and methodologies for attacking these problems on all fronts, political, religious, and whatever other avenues we can deal with, both parents and the students, at as early an age as possible.

We got one final concrete decision out of this; that is that Dr. Larry DeNeal, with the help of Dr. Evelyn Scott, is going to survey the institutions and members of this Society to ascertain the strategies and techniques that we are attempting to use to solve our problems through HCOP programs, recruiting activities, community activities and all sorts of things, and to compile those and share these strategies and techniques with us so that we will not become fainthearted and decide that the problem is bigger than we are; and we will continue, as so many of us have in the past, to try to agressively attack it.

HIGHLIGHTS OF CONCURRENT SESSIONS AND SPECIAL INTEREST GROUPS

ALLIED HEALTH PRACTITIONERS, CLINICIANS AND COMMUNITY HEALTH WORKERS

Lucille Hickman, B.S., R.P.T.
Instructor, Physical Therapy Program
College of Allied Health
Chicago State University
Chicago, Illinois

The focus of the Special Interest Group regarding Allied Health Practitioners, Clinicians and Community Health Workers included issues concerning recruitment of qualified Allied Health personnel, quality control in the education of students in health professions, interdisciplinary cohesiveness and compatibility among Allied Health occupations, and the movement of Allied Health professions toward economy and increased recognition.

Recruitment of qualified Allied Health personnel and quality control in the education of students in the health professions are intimately related. The quality of care given by the health practitioner is dependent in part upon his or her academic and clinical experience and competence, and in part upon well informed career decision making. The group decided that early intervention in terms of career counseling, planned opportunities for observation of a particular health profession, and the availability of information about varied Allied Health Professions built into the curriculum design could serve as a screening mechanism as well as a means for systematic health careers orientation.

The group as a whole expressed concern regarding the competitive environment that exists between many Allied Health occupations because of the overlap of professional duties. This competition oftentimes isolates Allied Health professionals from each other. In order for the Allied Health professions as a whole to grow to an economy, prestige and increased recognition, as well as, provide the right care that addresses the current medical needs of the Black population, the need to develop more effective ways of communicating differences and sharing occupational similarities must be addressed in a systematic fashion, and that includes students, patients, and profesional education. The current trends in health care, concerning health promotion and disease prevention can provide an excellent opportunity for Allied Health professionals to rethink and reorganize their roles in health care delivery. The National Society of Allied Health

provides an organizational framework from which these changes can be identified and addressed giving new meaning to the concepts of team approach and partnership in health care.

HIGHLIGHTS OF CONCURRENT SESSIONS AND SPECIAL INTEREST GROUPS

DEPARTMENT CHAIRS, PROGRAM DIRECTORS AND COORDINATORS

Catherine L. Tolson
Program Director, Medical Technology
School of Nursing and Allied Health
Tuskegee Institute, Alabama

Dr. Richard Bamberg, was recorder for the Special Interest Group discussion that focused on Leadership Development and from the discussions in that workshop, we saw eight ideas that emerged:

1. Everyone can be a leader ultimately, because leadership skills can be learned by observation, study and practice.

2. With those persons who innately possess leadership characteristics, their characteristics and skills will ultimately emerge even if they are never in a leadership role or situation.

3. The most central skills needed by a leader are to be a good communicator, to desire to serve others and be a good facilitator of change.

4. Mentoring is one key method to develop leaders, but mentors should expose the mentee to several leaders with a variety of styles in a variety of institutions.

5. Too many of the leadership development activities and programs are outside of our institutions. We need to have many more such activities on a consistent and in-house basis.

6. Persons become leaders for a variety of reasons. Sometimes it is not necessarily because they wish to become a leader, however, the goal should be once they become a leader for whatever reasons, to make the best leader possible through developmental opportunities.

7. We need to be cognizant of the tendency to overly concentrate on leadership, and we need to be aware that followers are also important. Most of the characteristics desirable in good leaders are also desirable in good followers and task executors.

Developmental activities and opportunities are needed for followers also,and equal dignity and worth should be given to followers as well as to leaders.

8. We could reward master clinicians and faculty just as we do their leaders and counterparts of clinical department managers, department chairpersons and deans. The rewards should be monetary, travel, research funds, promotional incentive and the like.

HIGHLIGHT OF CONCURRENT SESSIONS AND SPECIAL INTEREST GROUPS

FACULTY

Dr. Lillie Williams,
Chairperson Department of Dietetics
College of Allied Health Sciences
Howard University
Washington, D.C.

After you move into the chair, there are times when you may not be as completely in sync as you should be, so sitting in was really an inspiration. The other thing that was interesting about our session is that most of the attendees at the sessions were junior faculty, which gave our facilitator, Mr. Willie Dancil, a chance to act as a mentor and to give this group some insight and to give those of us who have been an active Dean for a short period of time, a fresh outlook, which was actually more educational to us than perhaps to the Dean. This was the faculty group and it was interesting. We were given a very large room because we expected quite a turnout. It may be something to look into the character of the faculty as we looked at what actually happened. This group, under Mr. Dancil, who has I think about 15 years in academia, talked about nine areas of concern that faculty face. He did this in light of a historical perspective. He told this young group who knew very little, one as a matter of fact had been on her job three days, so she was really young and anxious to know everything that he could tell her.

These programs actually started in the late sixties and at that time they were looked on with suspicion and actually rejected by the traditional departments. They were considered vocational groups and that they really didn't belong in four year educational programs. They tolerated them though, because even though they were suspicious of them and looked down on them; this new group of faculty, this new discipline brought a whole bunch of new students and with it, at that time, a lot of government money, a lot of funding. So they tolerated them; they put them in the smallest area; but they put up with them. Then around the 70's, you saw a different opinion emerge, according to Mr. Dancil, in that many of these clinicians who came over as academicians were given even higher salaries than the traditional faculty because their salaries had to compete with those of clinicians in the area. Then the 80's arrived, and most of these faculty had come on, and he said at this point, survival is often the case of many of our Allied Health programs. We are in a area of retrenchment of funds, and there is a real competition for the students. The nine areas that were identified, and Mr.

Dancil stressed that there were no priorities with these, but one area of concern is that many of the faculty were actually transferees that came in from a clinician role, without much educational background, without a whole view of what academia is except some ivory tower that, as most of us know, is not what we found when we got into academia.

In this connection, the group identified that often developmental time is not allowed. We come to the position in one week, and two weeks later, you're expected to produce a whole new world. Not only was developmental time not allowed, development was not provided for. But a young faculty person was often having to find for himself what he needed without even knowing what he needed, which was a very stressful situation for the young faculty person. In this connection, Mr. Dancil said that as faculty, we need to become aware of policy, find out if you're on a tenure track, and if you're on a tenure track, how long do you have, and what is actually required. The faculty was concerned that even though on one hand we say you must teach well, that you must carry a high faculty load, when you actually looked at the motion, the thing that was looked on critically was how much research have you done. How do you go about doing research when you are teaching five courses, and working on eight committees and expected to do some service and in addition, you may have 20 people to advise? It is pretty hard to do research, and yet that really determines how much you will love academia.

Another area that was pointed out, was that of tenure, which we led into quite gracefully. One of the concerns is that even though we say Allied Health is slightly different, when we actually begin to reach tenure, you're still expected to meet those same traditional criteria, where do we make that change or how do we bring these things into some type of an agreement. The other area was that of evaluation. They pointed out that they must put up with chairpeople in the evaluation, but that they felt that there was a need among faculty to begin to do some pure self-evaluation, and that they themselves are probably the best judge of when they are and how they are producing.

Research became an area, and the question was raised can Allied Health research be considered on the same par as basic research? When we go out to compete for funds, do we have the same body of funds out there to seek?

Relief time was discussed. What can we do to allow the faculty the opportunity to do some of these things that they may want to do?

The eighth area that was mentioned was that of interpersonal problems. The group felt that there were problems between

chairpersons, administrators and just plain interpersonal interaction, now knowing where they were, as one person said not sensitive to their needs. And it is really ironic as many of us as chair have been faculty, now how do we become so unaware as we move into a different position? One of the faculty said if they treated us as though we were important, we'd probably be much more productive. There became a discussion and a disagreement in the textbook that we had used at an earlier conference as to who is the most important person in the educational situation. The textbook by Allen Tucker had indicated that it was the chairperson; and the faculty group was skeptic; either we make that department, or we make that department not succeed.

The next to the last area was that of workloads. The general feeling is that the workloads are often not equally distributed, and that there needs to be some method established where we can really look at what is expected of an individual. And this all led into our last area, which was our theme for the conference which was "Partnerships in Health Promotions for Black Americans." This group felt that if they were going to do something about health promotion, it needed to start with them as individuals, but they are having trouble being good role models because they themselves are feeling so stressed. If the administrators would take this theme and try to apply it and try to make life a little bit better for them, they could start health promotion right there in their own facility.

The conclusion is that what is happening many times with our faculty and with the chair is that some place along the way we are saying the same thing; but we are not getting together to understand each other, and that through some mechanism, the problems that this faculty group brought up were things that could be worked with, things that we could do, situations that could be corrected, but often we do not know what that other person is talking about. We are not talking the same language and we are not interpreting the same things.

HIGHLIGHTS OF CONCURRENT SESSIONS AND SPECIAL INTEREST GROUPS

STUDENT

Arethea McClary, Vice Presient
Student Government, Speech Pathology and Audiology Student
Norfolk State University
Norfolk, Virginia

The purpose of this workshop was to introduce Epsilon Tau Sigma Honor Society of the National Society of Allied Health. The society was authorized by the Board of Directors in September, 1984. The Facilitator for our group was Raymond Wynn, who is the past President of the Student Council; he is a Radiation Therapy Student in the School of Allied Health Sciences at Howard University. He introduced the history of Epsilon Tau Sigma, after which he reviewed the constitution. We had a brief question and answer period. This was followed by a statement by Dr. Flack who said that the Board of Directors had a special session yesterday, and the Board had approved two chapters of Epsilon Tau Sigma. These chapters will be (1) Howard University's Chapter, which would be called the Alpha Chapter; and (2) Norfolk State University's Chapter, which would be called Beta Chapter. At this point, Norfolk State students decided to vote for their officers; and the officers are as follows:

Willie E. Austin, Jr., President,
Felicia McDougan, Vice-President,
Secretary/Treasurer, Arethea McClary.

We next voted for the National Officers, and they are:

Raymond Wynn, President,
Verdall Saunders, Vice-President,
Althea Cuff, Secretary/Treasurer, and
Arethea McClary would serve as Student Ex Officio.

We then took suggestions on a project for the upcoming year. We said that we would try to encourage other predominantly Black Universities to become members of Epsilon Tau Sigma and as with any organization we will try to get funding. At this point, Dr. Flack stated that he would supply our organization with $500.00 from his upcoming budget in order that we can start working.

On a personal note I would like to conclude by saying that I was very proud of the representation from both Howard University and Norfolk State.

THE PRESIDENTIAL ADDRESS

ARE BLACK ORGANIZATIONS STILL NECESSARY AND RELEVANT TO THE BLACK COMMUNITY?

Harry E. Douglas, III D.P.A., President
National Society of Allied Health

This year's meeting has a very special meaning for me for it was here in Virginia Beach that four individuals (Rachael Bettis, Andrew Bond, Donald Taylor and I) prepared the Bylaws and Articles of Incorporation for the National Society in Dr. Donald Taylor's living room and patio. We worked diligently as though this were a life and death situation, and little did we know, that this modest beginning would translate into such an organization. It was our belief that a group such as the NSAH could and ultimately would impact on the quality of education for minority health professionals and the delivery of services to underserved minority communities. We envisioned modest representation from those citadels of minority higher education:

-- Howard University
-- Texas Southern University
-- Tennessee State University
-- Florida A & M University
-- Norfolk State University
-- Tuskegee University
-- Hampton University
-- Clark College
-- Grambling University

And indeed we have representation, not modest, but strong representation from these institutions. While we did not anticipate it, we also have representation from:

-- The University of Vermont
-- George Washington University
-- The University of Oklahoma
-- Fresno State University

Additionally, we have representation from:

-- Government agencies
-- Community groups and
-- Non-profit health organizations
-- Business alliances from all sections of the country

And finally, we are co-sponsored by the local Norfolk Area Health Education Centers. Indeed, this is a remarkable achievement in a short period of time.

The Association has come a long way since that modest beginning, and we have done so in a very short period of time. But most importantly, we now have representation from a small, private, minority-oriented school from the West Coast. As its representative, I would like to say for our gang at that great bastion of higher education and learning, the Charles R. Drew School of Allied Health, that it is certainly nice to be back in Virginia Beach as an institutional member of the NSAH.

My theme for this evening will address the issue, "Are Black Organizations Still Necessary and/or Relevant to the Black Community?"

I am constantly asked this question by many of my White colleagues, as perhaps many of you are. I think this is a fair question. Unfortunately, we as Blacks have not always provided the most cogent and logical responses to the question, for whatever reason. To illustrate:

1. During the formative period of the National Society, a group of us met in San Francisco for the ASAHP meeting. Boy, we had a good time! We went to Chinatown, Fisherman's Wharf, and rode the cable cars; we enjoyed the city! It was all the more enjoyable because we had been disenfranchised by ASAHP. Specifically, we had been denied the historical privilege of appointing the Chair of the ERAH Committee. The Committee was formed by and for minorities concerned about a number of issues related to the disproportionate representation of minorities at all levels in the Allied Health field.

   This unilateral action on the part of ASAHP pushed the group into organizing its own association. The domination of the larger group forced us to examine and in some instances reexamine our position within ASAHP, and hence necessitated the organizing effort. The majority of you here tonight, as were those of us at that meeting in San Francisco, are leaders in his/her own communities, educational and social systems; and yet ASAHP did not, and does not afford you nor us the opportunity to exhibit and express our leadership potential. The NSAH indeed offers a vehicle modeled on participatory theory; namely, participation refers to equal participation in the making of decisions, and the justification for a democratic system in the participatory theory of democracy rests primarily on the human results that accrue from the participatory process. One might characterize the participating model as one where maximum input (participation) is required and where

output include not just policies (decisions) but also the development of the social and political capacities of each of us, so that there is feedback from output to input.

However, our initial responses and reaction to this lack of freedom to participate failed to address this reality. On the other hand, NSAH provides the vehicle for participation and power equality.

2. How many of you have been asked to appear on panels or give some sort of presentation to majority institutions on minority recruitment and retention programs? Several years ago I found myself preparing a paper utilizing a model I developed at Howard University on this topic. For some reason, I was quite troubled in attempting to put it together. Something was wrong; indeed, after much reflection, I discovered the context was different, for minority students at Howard University were White not Black. Hence. I was looking at the world through the eyes of the dominant system. When I switched lens, I discovered some interesting things; namely that our minority students were experiencing the same problems as Black students on TWI campuses, i.e., social isolation, clinging together, seeking out White professors (role models, etc.). The one exception - they, the White students, did not accept the authority system at the TBI. Why? Because they knew it was not the dominant structure! I presented this model at an ASAHP meeting with a prescriptive strategy for enhancing White student participation in TBI education programs. The response was overwhelming. I was invited to several TWI's as a consultant or guest lecturer. The message, of course, is clear. We need to study the impact that Black Social Systems are having on the dominant structure rather than always looking at what we are doing to ourselves. Black-on-Black crime, or what it, the broader system, is doing to us - for what we are dealing with is a problem which is systemic, and thus must be cast in a broader framework.

This is an important issue, for unlike a lot of us believe, there is not a theory of organization which sets Black organizations apart from others. "A theory is a statement in general terms about the likely relationship between two or more phenomena. It suggests hypotheses that it is possible to test and where necessary, refute. A theory of organization would explain why organizations are as they are, and examine the factors that make them

change. It would set out to offer an explanation on organizational structure and dynamics." Given the above, we can conclude that there is not one theory of organization, but theories of organization, i,e., a number of them, perhaps as many as there are people.

Thus, because we are confronted with so many such theories, it is my belief that, we often confuse issues about Black Institutions and their necessity and relevancy to the community. My experience suggests that it is enough to say that each organization defines its realities within its own culture, and further that what that reality is cannot be used to predict what will occur in another system. In a real sense then, each institution should function based on its own culture. This is a key consideration, for if there is any one factor which could set Black organization apart from others, it is culture. If you have ever visited a TBI you will have felt a sense of family, humanism, collective projects, community pride. Administratively, the institutions tend to replicate the dominant system. What causes this?

From a societal perspective, it has been established that a two-way relationship exists between organizational and societal structures. "Once created, organizations reflect the prevailing, meaning - structure of their time in their internal patterns of social relations. Thus, health institutions originating within a bureaucratized society will tend to be created with a bureaucratic structure." And from a systems perspective Black institutions of necessity must relate in some fashion to a dominant society whose values, norms and cultural patterns differ significantly from those manifested in the Black community. Indeed, there exists a basic conflict between our cultural patterns. Hence, the question is not whether or not Black institutions are necessary and/or serving the community, for th[illegible] certainly are; but rather, how can we help them to better mediate between the educational and service needs of the community from an egalatarian or socially purposeful perspective and at the same time survive in a capitalist system? This is the challenge!

To effectively address the challenge, it is essential that we view our health organizations, educational institutions and environment in dynamic terms; namely, that neither of the two has an independent existence. How about partnerships? Health organizations and educational institutions have autonomous (self-actualizing) tendencies as well as environmental factors which also influence the within system behavior. This latter issue, perhaps more than any other, influences the service levels of Black institutions. Specifically, 1) funding; 2) political influences; and 3) the market are the dominant

influences; and we have to this point in history exerted little, if any, control over them. To survive, we must begin to mount strategies which will ensure that we will indeed control our institutional destinies. One way to achieve such control is to more fully appreciate the biosphere dynamic of social systems.

Before I further develop this concept, I want to first address the issue more explicitly of whether Black institutions serve the needs of the community. As I indicated earlier, they unequivocally are serving the needs! The question is -- how?

After reviewing the statistics of minority groups in higher education, I think we all can get a better feel for how.

In terms of Blacks (the figures are just as dramatic for Hispanic and Native Americans) of the approximately 30 million, only two (2) million have bachelor's degrees. Of the two million, approximately 10 percent have master's degrees. Finally, less than one (1) percent of the total world population has a doctorate degree. The Chronicle of Higher Education recently reported that in 1983 approximately 30,000 doctorate degrees were awarded. Blacks received slightly under 1,000 of these. Over 50 percent were in education.

Further, The Third Annual Status Report "Minorities in Higher Education" reported that:

-- Blacks, Hispanics, and Native Americans continue to be under-represented in enrollment in four-year institutions.

-- Blacks experienced proportional enrollment declines at all post secondary levels.

-- Blacks experienced losses in proportional share of degrees earned at every level.

-- Blacks and Hispanics experienced increases in the number of high school graduates, but the percentage of high school graduates enrolling in college for both groups is declining.

-- Non resident aliens received more doctoral degrees than the total minority students in all fields except psychology, the humanities, and education. In the physical sciences, aliens received degrees at a rate of almost 3 to 1 over U.S. minorities.

Finally:

-- 25,600 Black males received bachelor's degrees in 1976, compared to 24,500 in 1981, a percentage

decrease of 4%.

-- 7,800 Black males received master's degrees in 1976, compared to 6,200 in 1981, a percentage decrease of 21%.

-- 800 Black males received doctor's degrees in 1976, compared to 700 in 1981, a decrease of 12%.

So, what does all this tell us about Blacks and other minorities? Essentially, that we are in trouble, because the dominant system has and continues to systematically exclude minorities from higher education, which in effect prevents us from developing the intellectual core we need to run our own institutions. Finally, for what little core that has been developed, let's examine how it was produced.

THE PARETO'S PHENOMENA

As an academician, I, like most of you (my colleagues) constantly find myself attempting to build models to explain certain phenomenon in a social context. Sometimes we become overzealous and carried away and hence, overlook some rather obvious models which are already in existence. The problem is that for whatever reason they have not been used in the context of our special circumstance.

In terms of my previous comment, i.e., limited core of minority students in higher education, and further not providing the most cogent and logical response for why Black organizations are still necessary and/or relevant to the Black community, I would be out of step with the rising-tide of conservatism to advance or espouse a model based on Rawl's theory of social justice to rationalize a need for change. We all know that story, it has been rehashed over and over. It won't sell in Peoria, because the approach is not predicated on a capitalist philosophy. On the other hand, when I hit my White colleagues with Pareto, they reply by saying, "Wow, that's heavy!" If I were to base my justification on Pareto's Law, I just might gain a few listeners. Pareto's Law simply states that in any social institution (this includes institutions of higher education):

-- 80 percent of the resources are used to produce 20 percent of the results, and

-- 20 percent of the resources are used to produce 80 percent of the results.

Let's examine this concept in terms of Blacks in higher education:

-- There are approximately 1 million Blacks attending college in the U.S. today.

-- 75-80 percent attend traditionally White instutitions.

-- 20-25 percent attend predominately Black institutions. The institutions include historical Black as well as institutions which have a predominately Black enrollment.

On the other hand:

-- Estimates indicate that between 65 and 80 percent of Black graduates from predominately Black institutions.

-- While 20-45 percent graduate from TWI's.

Now let us narrow our focus and look specifically at one Allied Health occupation; namely, the physician assistant profession. There are 51 physician assistant programs throughout the U.S. The profession consists of 2.8 percent minorities. Each year, approximately 1,500 students graduate. Of these 51 programs, 3 (5 percent) have a minority emphasis. They are Howard University, Harlem Hospital and the Drew School of Allied Health. These three schools graduate about 60 percent of all minority physician assistants. Hospitals are another example. Eighty percent of the resources are used for 20 percent of the patients (in-patients) and 20 percent of the resources are used for 80 percent of the patients (out-patient). I would suspect that Norfolk Community Hospital is an exception to this principle!

Given the Pareto Law and what we know about society, if you were intent on 1) increasing minority enrollment in the health professions and/or increasing health services for minority populations, what would you do?

-- Increase resource allocation for institutions producing 20 percent of the results or those producing 80 percent of the results.

In recent years the dominant system has increased the resources to the 20 percent producers while reducing resources for the 80 percent producers. This is not an abstract phenomenon. We are presently witnessing this effect in all of our institutions throughout the country.

THE BIOSPHERE

Pareto was no dummy. He was an Italian philosopher trained to

understand macro system as a sociologist, and self-interest motivation at the micro-level by studying economics. In effect, he understood the concept of biosphere dynamics.

And while we do need NSAH, we must continue to develop NSAH and all of our institutions within the context of a biosphere, so that we may more effectively serve our communities. And what is a biosphere? It is the life process of a social system. Specifically, a bisopheres has two indispensable poles: (1) Autonomous determination (self-regulation) tendencies, and (2) environmental determination (external governing process), i.e., (a) funding: (b) political influences; and (c) the market. Combined, the two processes are part of a single process -- the systems life. Hence, for our institutions to survive, grow and to effectively function, they must achieve a level of harmony between the two processes. (In other words we must form partnerships within our communities.) Given this reality, we must keep in mind that institutions designed for egalitarian purposes (only), will of necessity expend enormous amounts of energy and resources, resisting a major environmental force rather than accommodating to it. The force is Capitalism.

LEADERSHIP (A Mandate to Lead) - Thus, we have a mandate to provide the nation with purposeful leadership!

Leadership, contrary to what a lot of folks suggest, is a quality in which we are not in short supply. Indeed, each of us here is a leader within his/her various communities. And it is important that you recognize and understand that you are leaders. Several years ago I undertook a major research study. The subject was, "How to Deal With Environmental Uncertainty and Effectively Handle Transition During Turbulence." Minority institutions are certainly experiencing uncertainty and environmental turbulence, perhaps more so now than at any time since World War II. There were two key factors which emerged from the study, and I will mention them because they have relevance to our current circumstance.

1. Roles. The key stumbling block to survival and successful transition is role rigidity. For Blacks this is unfortunate because our roles are basically not organized around our natural roles in a cultural context. Hence, a conflict erupts between our natural state and the dominant societal system. We find our identifies in our roles and lose sight of self. We become prisoners of our own cognitive processes; and

2. Leadership. Of all the roles we assume, the leadership role is the most important. During periods of uncertainty, people look for action cues

from the leaders. How we respond, whether we understand it or not, will determine the institutions behavior.

The following illustrate my point:

I recently testified in behalf of the State of California - SB 1707. The Bill was designed to:

1. Increase the rate of allied health student admission and retention among minorities.

2. Expand the supply of medical care and reduce its cost through the use of allied health personnel and other personnel.

3. Reduce unemployment and underemployment in the state through increased education and training opportunities in allied health for disadvantaged populations.

4. Improve the health status of large segments of underserved and disadvantaged populations through the integration of applied health promotion and wellness strategies into the allied health education process.

At the conclusion of the Senate hearings, the Chair asked the question, "Was there any opposition to the Bill." The Committee report indicated no opposition. I looked over my shoulder and here was this lady, who said, "I oppose the bill". Now, who could oppose this motherhood and apple pie piece of legislation? Well, the lady was from the Statewide Health Planning Agency, the organization having responsibility for implementing legislation. For one thing, the bill would require role realignments in the agency, i.e., role rigidity; and further, the political leadership gave her her marching orders. Hence, she was taking her cues from the leadership.

In closing let me say that as leaders, I believe we have much more to offer society than to perform in passive roles and provide reactive rather than proactive leadership. Indeed, Blacks and other minority cultures have traditionally stressed a pattern of humanism unparalleled in Western civilization. This pattern of humanism is one of the foundations upon which Black health and educational institutions have been built. Where others failed, we, meaning all of us, must carry on this tradition, and in the long-run (like Black music, and Blacks in sports) our institutions will become the nation's dominant model.

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Dr. Bond was previously dean of the special academic program that preceded the School of Allied Health Professions, which was established in 1974 as a joint venture of Meharry Medical College, Tennessee State University and Fisk University. He had formerly served as professor and chairman of the Department of Biochemistry at Tennessee State University.

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Harley E. Flack, Ph.D., has been Dean of the College of Allied Health Sciences Department of Howard University since 1974. He was Assistant Dean, School of Health Related Professions, State University of New York at Buffalo from 1971 to 1974. Prior to that time, Dr. Flack held a number of challenging positions with the State Univesity of New York at Buffalo.

Dr. Flack earned his B.S. in Physical Therapy at Ohio State University in 1965; the M.S. degree in Rehabilitation Counseling was earned in 1968 at Kent State University, and the Ph.D. in Counselor-Education was earned in 1971 from State University of New York.

Dr. Flack has authored publications concerning allied health topics in the Urban Health Magazine, the Journal of Allied Health and others.

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Lucille Hickman, B.S., R.P.T.
(Continued)

director of a developing physical therapy program (Chicago State University).

Ms. Hickman is also completing degree requirements for a Master's Degree in Health Professions Education (Governor State University) and is actively involved in EMG/NVC studies, both with testing and evaluation of neurological disorders.

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GLORIA G. LAWLAH, M.A.T.

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Dr. Thomas E. Malone is the number two man at the internationally respected National Institutes for Health in the Department of Health and Human Services. He is a veteran career civil servant whose leisure time acivities include teaching judo, flying airplanes and relaxing to classical music.

Since 1977, Dr. Thomas E. Malone has been deputy director of NIH, the sprawling complex in Bethesda, Marland, a suburb of Washington, D.C., which is the principal agency in the federal

Thomas E. Malone Ph.D.
(Continued)

government for the conduct and support of biomedical research throughout the United States and in many other countries. He was acting director of the multi-billion dollar ($4.5 billion in 1984) organization for almost a year, from July 1981 to May 1982.

Dr. Malone was born in Henderson, N.C., June 3, 1926. He received his bachelor's and master's of science degrees from North Carolina Central University, Durham, in 1948 and 1949 respectively, and his Ph.D. from Harvard University in 1952. He was appointed to the faculty of North Carolina Central in 1952 where he was professor of zoology until 1958 when he accepted a National Academy of Sciences postdoctoral fellowship to serve for a year as a research associate at Argonne National Laboratory.

Over the next three years, until joining the NIH staff in 1962, Dr. Malone was a member of the faculty of Loyola University in Chicago.

After five years as a NIH research administrator, he was named professor and chairman of the department of biology at the American University of Beirut, Lebanon. In 1969, he returned to the NIH as associate director of the National Institute of Dental Research, responsible for its extramural programs.

He was named NIH associate director for extramural research and training in 1972, a key position he held until his 1977 appointment as NIH deputy director.

He has participated in numerous international health activities and has been a member of the U.S. delegation to the 31st, 32nd, and 33rd and 34th World Health Assemblies in Geneva.

Dr. Malone heads the Task Force on Black and Minority Health, established early this year by Health and Human Services Secretary Margaret M. Heckler. It is conducting a comprehensive study of the factors responsible for the disparity that exists between the health status of minorities and the population as a whole. The task force is composed of high-level departmental officials and will recommend ways for redirecting federal resources to narrow the health differences between minorities and whites and to suggest ways in which the public and private sectors can cooperate for that purpose.

In his career as a federal scientist/administrator, Dr. Malone has received numerous awards, including the Superior Service Award of the Department of Health, Education and Welfare in

Thomas E. Malone, Ph.D.
(Continued)

1971, and the DHEW Distinguished Service Award in 1974. He was given the President Merit Award of the Senior Executive Service in 1980.

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Arethea McClary is Vice President, Student Government, and a Speech Pathology and Audiology Student at Norfolk State University, VA.

FRED MCKINNEY, Ph.D.

Dr. Fred McKinney is currently an Assistant Professor at the Florence Heller Graduate School for Advanced Studies in Social Welfare. He is writing and doing research on Allied Health Labor Markets. The research is funded by the Commonwealth Fund of New York. The focus of the research is to determine the outlook for Allied Health workers, with particular emphasis on minority allied health workers. In addition to these research activities, Dr. McKinney teaches Health Discrimination at the Heller School. Before coming to Brandeis, Dr. McKinney taught at Sacred Heart University in Bridgeport, Connecticut. He was a consultant to the Rand Corporation in Santa Monica, California and he spent one year on President Carter's Council of Economic Advisors. Dr. McKinney received his Ph.D. in Economics from Yale University in 1983.

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Mary Redd earned a Bachelor of Arts degree in Sociology at the Virginia Union College. She is currently Executive Director of the Urban League of Tidewater, Virginia.

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Mitchell F. Rice is Associate Professor of Political Science and Public Administration at Louisiana State University, Baton Rouge. He holds the Ph.D. in Government from Claremont Graduate School. He is the recipient of a 1985-86 Rockefeller Foundation Postdoctoral Research Fellowship. He has held a National Research Council Ford Foundation Postdoctoral Fellowship and an American Council on Education Fellowship in Academic Administration. He has taught previously at Prairie View A & M University and Southwest Texas State University. He has written over 50 articles and papers on such topics as Black health care, affirmative action and EEO, urban policy and legal issues in racial discrimination. He is coeditor of Contemporary Public Policy Perspectives and Black Americans: Issues In An Era of Retrenchment Politics (Greenwood Press, 1984). He has published articles in a number of academic and professional journals including American Review of Public Administration, and Policy Studies Review. He is presently coediting a book on "Black Health Care."

BILLIE T. SHEPPARD, M.S.P.H.

Ms. Billie T. Sheppard has actively been involved in health work and concerns in the District of Columbia for 15 years and intermittently in South-East Asia. In the past, she was active in Community Health Center development, working at the Cardoza Neighborhood Health Center and providing technical assistance throughout the city. She also assisted in the formulation of research on ability basis for data collection of university and federally sponsored health programs with Harvard University School of Public Health. Ms. Sheppard served as the Regional Director for the National Medical Development Specialist to 22 historically and predominately Black institutions supported by the United Negro College Fund, Inc. Professional activities have included appointments to the District of Columbia Health Commission Panel and delegate to the College Entrance Examination Board, Princeton.

Currently, she co-chairs the Health Sub-Committee of the Mayor's Blue Ribbon Panel on Teenage Pregnancy Prevention in the District of Columbia. She is project director of the Health Promotion, Disease Prevention Program for high-risk young people and assistant professor at Howard University College of Allied Health Sciences. Ms. Sheppard has a Master of Science in Public Health (M.S.P.H.) from Howard University College of Medicine.

THE HONORABLE LOUIS STOKES

On November 5, 1968, Louis Stokes was elected Congressman of the 21st Congressional District, Ohio, on his first try for

The Honorable Louis Stokes
(Continued)

public office. By virtue of his election, he became the first Black member of Congress from the State of Ohio. On November 2, 1982, he was re-elected to his eighth term in Congress. During his first term in Congress, he served as a member of the Education and Labor Committee and the House Un-American Activities Committee, which was renamed the House Internal Security Committee.

In his second term of office he was appointed the first Black member ever to sit on the Appropriations Committee of the House. On February 8, 1972, Louis Stokes was elected as Chairman of the Congressional Black Caucus. He served two consecutive terms in this office. In addition to his seat on the powerful Appropriations Committee, on February 5, 1975, he was elected by the Democratic Caucus to serve on the newly formed Budget Committee of the House. He was re-elcted to the Budget Committee twice, serving a total of six years. He is also Co-Chairman of the Congressional Black Caucus Health Brain Trust and President of the Congressional Black Caucus Foundation, the non-profit charitable contribution arm of the Congressional Black Caucus.

On September 21, 1976, Congressman Stokes was appointed by Speaker Carl Albert to serve on the Select Committee to Conduct an Investigation and Study of the Circumstances Surrounding the death of President John F. Kennedy and the death of Dr. Martin Luther King, Jr. On March 8, 1977, Speaker Thomas P. "Tip" O'Neill appointed Congressman Stokes Chairman of this Committee. On December 31, 1978, Congressman Stokes completed these historic investigations and filed with the House of Representatives 27 volumes of Hearings, a Final Report and Recommendations for Administrative and Legislative Reform.

In February, 1980, Congressman Stokes was appointed by Speaker O'Neill to the House Committee on Standards of Official Conduct (Ethics Committee). On January 28, 1981 the Congressman was elected Chairman of this Committee. He was re-elected to serve as the Ethics Committee Chairman at the beginning of the 98th Congress.

In January, 1981, Congressman Stokes became the Senior Democratic Representative from Ohio and he serves as the Dean of the Ohio Democratic Congressional Delegation.

Congressman Stokes was presented the William L. Dawson Award by his colleagues at the Congressional Black Caucus on September 27, 1980. He has been named by Ebony Magazine as one of the 100 most influential Black Americans each year since 1971.

The Honorable Louis Stokes
(Continued)

Congressman Stokes is a product of the Cleveland Public Schools (Giddings and Central High School), Western Reserve University, and the Cleveland Marshall Law School the Cleveland State University where he earned his Doctor of Jurisprudence. Congressman Stokes has been presented honorary Doctor of Laws degrees by Wilberforce University, Shaw University, Livingstone College, Morehouse College, Meharry Medical College, and Atlanta University; Doctor of Humane Letters by the Ohio College of Podiatric Medicine, and Doctor of Humanities by Oberlin College.

He has references in Who's Who in America, in American Law, in American Politics, in the Midwest, in Health Care, Among Black Americans, Community Leaders and Noteworthy Americans.

DONALD TAYLOR, Sc.D.

Donald Taylor, Sc.D., is Dean of the School of Health Related Professions and Natural Sciences, Norfolk State University, Norfolk, Virginia.

Formerly he was Director of Health Sciences and Services at Norfolk State. Prior to that, he was coordinator of Health Sciences at Cheyney State College in Virginia.

Dr. Taylor earned his Bachelor's degree at Shepherd College, Shepherdtown, West Virginia, in Biology and English. His Masters work was done at Villanova University in Pennsylvania in Cell Biology. His doctoral degree in Pathobiology was earned at Johns Hopkins in 1970.

Dr. Taylor is an ordained Baptist minister, and earned his Masters of Divinity degree at the School of Theology, Virginia Union University, Magna Cum Laude in 1983. He is pastor of the Greater Mount Zion Baptist Church, Chesapeake, VA.

Dr. Taylor just recently authored the Allied Health Professions Admissions Test published by Arco Publishing Company, 1984.

CATHERINE LOWE TOLSON, M.Ed.

Catherine Tolson completed her B.S. degree in medical technology at Temple University and her Masters degree in Allied Health Education and Administration at the University of Houston/Baylor College of Medicine. Ms. Tolson has worked in the Veterans Administration Hospital System for the past 27

Catherine L. Tolson, M.Ed.
(Continued)

years; first as a generalist for 11 months in Augusta, GA; then in Houston, TX, as a chemistry technologist/educator for the next 10 years, followed by nine years as a microbiologist/educator. For the past seven years she has served in a dual appointment at VA Medical Center and Tuskegee University as the first program director of Tuskegee University's Medical Technology Program which uses VAMC as its primary clinical facility. Ms. Tolson is a member of National Society of Allied Health, American Society of Medical Technology, and its subsidiary, The Forum for Minority Concerns.

PRIMUS WHEELER, JR., MST, RRT

Primus Wheeler, Jr. is Chairman and Associate Professor of Respiratory Therapy for the University of Mississippi Medical Center in Jackson, MS. He holds an Associate degree in Respiratory Therapy from Hinds Junior College, a Bachelor of Science degree in Biology from Tougaloo College, and a Masters of Science in Teaching from Jackson State University. He is Registered (RRT and Certified (CRTT) by the National Board for Respiratory Care. He is a member of the Phi Kappa Phi, National Honor Society. He is past president of the Mississippi Society for Respiratory Therapy. He holds current memberships with the Mississippi Society for Respiratory Therapy, Mississippi Heart Association, Mississippi Cystic Fibrosis Foundation, and the National Society for Allied Health.

LILLIE R. WILLIAMS, Ph.D., R.D.

Dr. Lillie Williams has been the department chairperson of the Department of Clinical Nutrition within the College of Allied Health Sciences at Howard University since 1980. Her original position with that department was as assistant professor in 1975. She has a doctoral degree in Nutrition. Her areas of research interest are cancer and food consumption. Dr. Williams had been a clinical clinician for 12 years prior to joining the faculty at Howard.

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